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1 UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF NEW YORK  
2 - - - - - X  
3 : 99-CV-7392 ROBERT A. FALISE;  
LOUIS KLEIN, (JBW)  
4 JR.; FRANK MACCHIAROLA; and : CHRISTIAN E. MARKEY, JR.,  
5 AS TRUSTEES, :  
6 Plaintiffs, : United States Courthouse  
-against- Brooklyn, New York  
7 : THE AMERICAN TOBACCO COMPANY;  
8 R. J. REYNOLDS TOBACCO COMPANY; : BROWN & WILLIAMSON TOBACCO  
January 12, 2001  
9 CORPORATION; : 9:00 a.m. PHILIP MORRIS  
INCORPORATED;  
10 LIGGETT GROUP, INC.; and : LORILLARD TOBACCO COMPANY,  
11 : Defendants.  
12 - - - - - X  
13 TRANSCRIPT OF JURY TRIAL BEFORE THE  
HONORABLE JACK B. WEINSTEIN  
14 UNITED STATES DISTRICT JUDGE  
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page 5670  
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21 Proceedings recorded by mechanical stenography.  
Transcript produced by CAT.  
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1 (Open court.)  
2 THE COURT: Falise for trial.  
3 MR. STENGEL: Good morning, your Honor.  
4 THE COURT: Good morning. What can I do for you?  
5 MR. STENGEL: Your Honor, I think there are some  
6 document issues.  
7 I apologize for not having been here at the end of  
8 the day. I have both Mr. Austern from the Trust and Dr.  
9 Harris available at this point in time, and would  
10 anticipate -- we had anticipated, as your Honor knows, putting  
11 on just Dr. Harris and doing not only rebuttal of the some of  
12 the issues raised by Dr. Wecker, but putting in the Trust  
13 numbers through Dr. Harris.  
14 If the court feels it would be more appropriate for  
15 the dollar amounts actually paid in toto to be put on by a

16 Trust witness, Mr. Austern is able to do that.  
17 THE COURT: That is up to the defendants. How do  
18 you want to handle the numbers?  
19 MR. BERNICK: We have a series of problems. Did the  
20 court receive our correspondence this morning?  
21 THE COURT: I received your correspondence with  
22 respect to the model, plaintiffs' testimony on the model.  
23 MR. BERNICK: There was also in the same  
24 correspondence -- it dealt with the Trust's damage claim.  
25 THE COURT: I didn't notice that, I'm sorry.

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1 MR. BERNICK: I will just recap for the court.  
2 Yesterday evening, your Honor, around 7:00 o'clock, we  
3 received a new set of numbers. Then even later on in the  
4 evening we got a further set of numbers later on that related  
5 to the consumer protection statute claim in particular.  
6 Both these sets of numbers share a couple or three  
7 fundamental defects that make it very difficult to proceed.  
8 Number one, is that neither one of them, as far as we can  
9 determine, are in accordance with your Honor's order that the  
10 only claims that would be recoverable are those that have been  
11 either paid or approved for payment as of December 31 of the  
12 year 2000.  
13 Unless something else has changed, I believe that  
14 both of these calculations or both of these claims would  
15 include claims that are actually approved for payment after  
16 the end of 2002.  
17 THE COURT: After 2002?  
18 MR. BERNICK: After 2002. The claim would come in,  
19 the Trust would expect that it would be paid, but it wouldn't  
20 actually be paid --  
21 THE COURT: That is not my ruling.  
22 MR. BERNICK: That is my understanding. Maybe  
23 something has changed, but all that we received were the  
24 numbers.  
25 At this point we don't know whether the numbers are

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1 in accordance with your Honor's order.  
2 THE COURT: Let's find out. That is easy enough.  
3 Let's find out what the numbers are.  
4 MR. STENGEL: The easy way to do this, I suppose, is  
5 to put these on the Elmo. We have similar presentations for  
6 each of the three causes of action and, as Mr. Bernick  
7 mentioned, because of yesterday morning's ruling on the  
8 Consumer Protection Act, that has been the last to come  
9 through.  
10 What we have done on each is present this in three  
11 pieces. The first calculation is the -- I have extra copies  
12 if it will be easier --  
13 THE COURT: No, I can use the Elmo.  
14 MR. STENGEL: The first calculation or presentation  
15 is settled claims as of 12/31/2000, literally claims that were  
16 resolved through the Trust, which I believe is in full  
17 compliance with the court's order.  
18 We have broken down the presentation because we  
19 think, when we moved to try and capture claims through 2002,  
20 it does create what is an anomaly because we have a  
21 substantial quantity of claims that were in the possession of  
22 the Trust as of the end of 2000, which we know from the Trust  
23 normal operations will be resolved -- if you recall, Professor  
24 Harris presented a transition matrix, I believe it's Harris 9

25 or 10, to explain how he took unresolved claims and turned  
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1 them into resolved claims.

2 Finally, we have a set of calculations --

3 THE COURT: Excuse me. I want you to follow my  
4 instructions. If your expert is doing it in a slightly  
5 different way, it may require some kind of reconstruction by  
6 the jury, but I want it presented my way, that is up to the  
7 end of the year 2000, paid or approved for payment, without  
8 any leakage into 2001.

9 MR. STENGEL: The claims as of the end of 2000, paid  
10 or approved, would be the first set of numbers.

11 THE COURT: That is --

12 MR. STENGEL: Ninety-four million.

13 THE COURT: Eighty-four million?

14 MR. STENGEL: Ninety-four.

15 THE COURT: Sorry. 94 million. Okay.

16 MR. STENGEL: Yes.

17 THE COURT: Is there any problem with that, that the  
18 defendants have?

19 MR. BERNICK: No. If that's as being represented,  
20 we believe that that would be in accordance with your Honor's  
21 ruling.

22 THE COURT: They just put in the sheet without a  
23 witness?

24 MR. BERNICK: As far as I can determine, that is not  
25 a problem from our point of view.

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1 THE COURT: What about 2001, 2002?

2 MR. STENGEL: Well, your Honor, we have --

3 MR. BERNICK: Sorry, your Honor, the one that I was  
4 speaking to is the 94. The second number is actually the end  
5 of the year 2000 unresolved. It's not 2002, it's 2000  
6 unresolved.

7 THE COURT: The first subhead is "settled claims as  
8 of 12/31/2000." That comes in. It ends with 94 plus  
9 million.

10 MR. BERNICK: Right.

11 THE COURT: The second group, "unresolved claims as  
12 of 12/31/2000," is out. That is to be redacted because it  
13 doesn't bear on what I asked for.

14 Right?

15 MR. STENGEL: Correct, your Honor.

16 THE COURT: Okay. Now we get into the 2001 through  
17 2002. Let's raise that up on the machine, please.

18 I'm not sure, is this what you expect to have paid or  
19 approved at the end of 2002?

20 MR. STENGEL: This is -- we get into projections  
21 here, your Honor, what the 2001 through 2002 is, taking  
22 Professor Florence's estimates of the claims that will be  
23 filed by year end 2002.

24 THE COURT: That is not the figure I asked for. It  
25 had to be reduced by the ratio of claims approved and paid to

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1 claims made because you don't pay all your claims.

2 What is the ratio? Bring the witness up.

3 MR. BERNICK: These are exactly the same questions I  
4 asked about twenty-four hours ago.

5 THE COURT: All right. We'll get you your answer, I  
6 hope.

7 THE WITNESS: Could I use this chart.  
8 THE COURT: Give your name for the record.  
9 THE WITNESS: David Austern.  
10 THE COURT: You are still under oath, Mr. Austern.  
11 D A V I D A U S T E R N,  
12 called as a witness, having been previously duly  
13 sworn, was examined and testified as follows:  
14 THE WITNESS: Yes, your Honor.  
15 MR. BERNICK: One detail, your Honor. If we go back  
16 up to the first one, just so that we can be clear --  
17 THE COURT: Are you using an erasable chart? Is  
18 there a piece of paper on that?  
19 THE WITNESS: No, there isn't.  
20 THE COURT: I don't want erasable charts. I want  
21 paper.  
22 MR. BERNICK: The first one includes -- this should  
23 be redacted as well. That is the total cost to the Trust that  
24 is not at issue.  
25 They should just have the 10 percent that they are

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1 seeking. This is not a cost to the Trust. They haven't paid  
2 that money. If they want to say it's a scheduled value, they  
3 can say that.  
4 THE COURT: Column 5 is out. Column 5 is to be  
5 redacted. Is that understood by the plaintiffs?  
6 MR. STENGEL: Yes, your Honor.  
7 THE COURT: All right. Put down there Austern 1.  
8 THE WITNESS: Your Honor, if one assigns on a  
9 vertical axis the alleged categories that one can receive, it  
10 would be 1 through 7, and if one, on the horizontal axis, has  
11 the categories that are paid, which is, of course, also 1  
12 through 7, and run through the 300 thousand, approximately,  
13 TDP claims that have in fact been paid, one can look at the  
14 alleged disease for those 300 thousand and chart it as against  
15 the paid, and what one ends up with, of course, is a  
16 horizontal axis because the 1's would be overwhelmingly paid  
17 as 1's and the 2's as 2, etcetera.  
18 THE COURT: You'll have to use the ratios for each  
19 disease then.  
20 THE WITNESS: If I can just mention, your Honor, we  
21 can supply a transition matrix. For most of the categories we  
22 know that a very large percentage of what comes in as an  
23 alleged 1 is paid as a 1, all the way down to 7.  
24 I'm sure it will not surprise the court to hear that  
25 when you GET to category 7, because we rely on pathological

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1 evidence, the ratio exceeds 90 percent. There are not very  
2 many doubts about pleural disease, the ratio is very high.  
3 Category 4 is not a very high ratio because of the  
4 other cancers being multifaceted.  
5 In any event, we know the transition matrix and, in  
6 fact, we employ it, not so much for this purpose, but for the  
7 purposes of cash reserves, thus, if we have 60 thousand  
8 pending claims, we have a pretty good idea during the year  
9 what our cash needs would be, based on the alleged versus the  
10 paid.  
11 That is how we ascertain it. I can tell your Honor  
12 that as of 12/31/2000, there were 26,863 claims that had in  
13 fact been categorized where there were checks outstanding but  
14 uncashed.  
15 THE COURT: Those are okay. Any check you cut or

16 approved for payment is okay. They come in.  
17 To get back to the question we have. As of the end  
18 of 2000 you have the figures, actual figures. As of the end  
19 of 2002, can you apply your ratios to lung cancer, disabling  
20 BID and BID?

21 THE WITNESS: Based on Dr. Florence's figures, we  
22 can.

23 MR. BERNICK: Can I ask a question, your Honor?

24 THE COURT: Sure.

25 MR. BERNICK: Haven't you already done it?

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1 THE WITNESS: I would have to check to see if we  
2 have a transition matrix for the 2001 and 2002 categories.

3 MR. BERNICK: That's not -- my question specifically  
4 is, has the Trust performed, even on a preliminary basis,  
5 exactly the determination that the court just asked? Have you  
6 done it or not?

7 THE WITNESS: I have not done it. I do not believe  
8 it has been done, but I can find out.

9 THE COURT: When are you going to do it? I'm  
10 allowing you to put in proof on those two years, but you have  
11 to have it set. We're at the end of the case.

12 MR. STENGEL: I understand that, your Honor. We  
13 have been, I think, trying to get this done with a fair number  
14 of other moving parts at the same time.

15 Just let me -- can we go back to current claims? As  
16 I understand where your Honor is at the moment, would it be  
17 acceptable --

18 MR. BERNICK: I'm sorry. Mr. Austern's answer is  
19 disconcerting to me. It is hard for me to believe that, given  
20 what he has said with such assurance and clarity, the Trust  
21 doesn't know what that number is paid.

22 That Mr. Austern doesn't know it is somewhat  
23 astonishing, because I put exactly the same question to  
24 Mr. Stengel twenty-four hours ago, and your Honor ruled, I  
25 don't know whether it was three days ago -- Dr. Harris is

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1 here, other people from the Trust are here. Yesterday  
2 afternoon, it was convenient that nobody was here to be able  
3 to answer these questions.

4 Is there somebody else that the court can ask in the  
5 courtroom who can give us the number?

6 THE COURT: Excuse me. Let me concentrate on lung  
7 cancer. You expect lung cancers -- what you call "defendants'  
8 misconduct at the end of 2002" -- to be what?

9 MR. BERNICK: Those are pilots.

10 MR. STENGEL: These are transition numbers.

11 THE COURT: What is that?

12 MR. STENGEL: They have been through this process.

13 MR. BERNICK: So --

14 THE COURT: How many claims for lung cancer do you  
15 expect to get in the year 2001, 2002?

16 MR. STENGEL: This is extracted from Dr. Florence's  
17 work. This is for 2001, 2002. The filings expected --

18 THE COURT: Okay, those are your filings?

19 MR. STENGEL: Right.

20 THE COURT: So your filings for 2001, 2002 forecast  
21 are 3,023, correct?

22 MR. STENGEL: If you include the Maritime Asbestos  
23 Litigation Clinic claims, it's 3,161.

24 THE COURT: Okay. How many of those do you expect

25 to approve for payment? What is your ratio as to lung cancer?  
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1 THE WITNESS: I'm sorry, your Honor, I was listening  
2 to someone else.

3 THE COURT: That's all right.

4 MR. STENGEL: These have been transitioned to these  
5 numbers.

6 MR. BERNICK: They haven't been. They can't be.  
7 This is what is so strange, your Honor. If you take a look at  
8 what Mr. Stengel just put on the screen, he says with  
9 defendants' misconduct, which is the status quo, the number is  
10 3466. That is future claims 2001 through 2002.

11 The number he just showed you is actually less. It  
12 says a total for 2001, 2002 as being 3023 and, including  
13 filings, 3161. They don't match.

14 THE COURT: Take your 3,161. What is the ratio of  
15 lung cancer claims that you approved?

16 MR. STENGEL: The transition matrix isn't presented  
17 here. He's asking what the transition is as to lung cancers.

18 THE WITNESS: I would have to pull the transition  
19 matrix. I can tell you that the percentage is very high, but  
20 I will have to get you the percentage.

21 THE COURT: What do you mean by "very high"?

22 THE WITNESS: I believe lung cancers are a plus 70  
23 percent alleged versus --

24 THE COURT: That's a big number.

25 THE WITNESS: It is, your Honor.

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1 THE COURT: Seventy times 3000 is a lot less than  
2 3000?

3 THE WITNESS: I understand that.

4 THE COURT: I have to have these numbers.

5 THE WITNESS: I will get you the numbers.

6 THE COURT: Get them. If necessary, have somebody  
7 on the stand who can be cross-examined and put them in that  
8 way, then we'll know. Okay?

9 MR. BERNICK: I don't have any problem with that,  
10 your Honor.

11 THE COURT: I don't want to do it solely on the  
12 basis of these type pages because I don't have enough security  
13 about their etiology.

14 Now, let me get to another point while you're all  
15 here before me. There has been ample evidence that lung  
16 cancer is caused by smoking.

17 Are the plaintiffs satisfied that they have put in  
18 enough evidence that disabling BID and BID are caused by  
19 smoking?

20 MR. STENGEL: Certainly that the conditions are  
21 exacerbated by smoking, particularly in the context of leading  
22 to more claims against the Trust.

23 THE COURT: You are satisfied you have?

24 MR. STENGEL: Yes, your Honor.

25 THE COURT: All right. Then we need the numbers on

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1 that, subject, of course, to motions at the end of the case.

2 MR. STENGEL: Your Honor, just for this morning's  
3 proceedings, Dr. Harris is available to talk about these  
4 numbers. He is the person who did the transition for the  
5 future claims.

6 As I understand your ruling, we need to redact the

7 column 5, the cost to the Trust, because the defendants object  
8 to that being included because it's the all in 100 percent  
9 number.

10 THE COURT: Well, I don't care if you have it in, as  
11 long as it's explained. It's not actually the cost, it's the  
12 liability of the Trust.

13 MR. BERNICK: The scheduled value.

14 THE COURT: Or scheduled value, but it's not the  
15 cost. Just change it.

16 MR. BERNICK: This does not deal with the -- if you  
17 want to flip up -- the consumer protection action.

18 THE COURT: The consumer protection action, again,  
19 that is a model problem not a problem of 2001, 2002.

20 MR. BERNICK: That's true. If they want to present  
21 these numbers, the numbers assume the problem with the model,  
22 as your Honor knows, at least that we have with the model,  
23 which is that it doesn't really tie to conduct.

24 THE COURT: That is their burden to prove. I'm not  
25 going to intervene.

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1 MR. BERNICK: As a practical matter, your Honor, I  
2 believe that if they wanted to, they could have the numbers  
3 that we need even before 10:00 o'clock.

4 I've got a witness to call to the stand who needs  
5 that number. We said that before. I need to know what that  
6 number is.

7 THE COURT: Get on the phone and get your people to  
8 work.

9 MR. STENGEL: Let me just -- Mr. Bernick and I have  
10 apparently miscommunicated on this before.

11 What you are looking for is settled claims plus  
12 claims where the checks have been cut, is that what you're  
13 looking for?

14 MR. BERNICK: I'm looking for the Trust to comply  
15 with the court's direction to present the damage claim in this  
16 case in accordance with the court's orders, that's what I  
17 want, so that my expert can say, here's what the damage claim  
18 is. Here's what it means.

19 It's just that simple. It seems to me the court has  
20 given the direction. It's just a question of doing something  
21 that ought to be extremely simple, which is adding to your  
22 first number whatever number represents the additional claims  
23 that will be approved, given your matrix, by the end of the  
24 year 2002. It's just that simple.

25 THE WITNESS: Your Honor, at the risk of

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1 complicating this matter, may I make just one observation  
2 before I retire to have someone do the numbers?

3 THE COURT: Sure.

4 THE WITNESS: If you look at lung cancer, which, as  
5 your Honor will recall, is category 5 and category 6, I will  
6 tell you that 5's and 6's that come in as lung cancers, 86.3  
7 percent -- I just looked -- are paid as lung cancers, but I  
8 may I point out to the court that category 1 claims that come  
9 in as alleged category 1's are sometimes paid as category 6,  
10 because we did medicals, all the way 2, 3 and 4.

11 THE COURT: Excuse me. I don't care what happens.  
12 All I want is the information I've asked for. If you can't  
13 supply the information in some semi-credible form so that a  
14 trier can rely on it, then you haven't made your case.

15 MR. STENGEL: Your Honor, I think there is one



16 confusion which I just picked up from Mr. Bernick's comment.  
17 This may just believe our imprecision in labeling.

18 What are called "unresolved claims," those  
19 include -- these have all been transitioned, and those include  
20 all the claims as to which there are checks outstanding which  
21 have not been cashed. So "unresolved" is not filings, these  
22 are all matrix; this is the Trust expectation.

23 THE COURT: You can't have them both ways. You  
24 can't have them as claims approved up to December 31 2000 and  
25 also incoming claims as of 2001.

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1 MR. STENGEL: Your Honor, these two collections of  
2 claims are both claims which were physically at the Trust.  
3 The difference is the top group, what we call "settled," means  
4 a check was cut and it was cashed. That transaction is  
5 completely final with the plaintiff.

6 The "unresolved" are at the Trust, many of them have  
7 been categorized, checks cut, but they haven't been accepted  
8 yet, but all of them have been through the transition matrix  
9 that Mr. Austern describes.

10 THE COURT: Excuse me. Present it any way you  
11 want. You know what I think you need to make a case. The  
12 rest is up to you. I'm not going to make the case for you.

13 MR. BERNICK: The difference between these two  
14 categories is irrelevant. The question is as of the end of  
15 the year 2002 is going to be proof of payment.

16 I feel very uneasy, your Honor. You ask, well, do  
17 you accept the numbers? I'm really going on, in a sense, the  
18 representation of the Trust that that first category has in  
19 fact been paid.

20 I'm going on Mr. Austern's representations in court  
21 and counsel's representations in court to that effect. When  
22 we get to these other categories, the more I hear the more  
23 nervous I get about accepting that representation.

24 We're talking about millions and millions of  
25 dollars.

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1 THE COURT: Even as to that first category,  
2 apparently, from what Mr. Austern has said, some of that first  
3 category is shifted into the 2001 because you've cut the  
4 checks but they haven't been cashed.

5 (Continued next page)

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1 MR. BERNICK: That's what makes me then leery of  
2 exactly what's in that second category.

3 MR. STENGEL: That's just not correct, Your Honor.  
4 What's in the first category, checks have been cut and  
5 cashed. Settled means we are done with the plaintiff. Fully  
6 resolved.

7 THE COURT: Okay. Okay.

8 MR. STENGEL: If I introduced any confusion on the  
9 second category I am sorry. The first category is absolutely  
10 done.

11 THE COURT: Okay. All right. Present it in any way  
12 you wish.

13 MR. BERNICK: We then have the very substantial  
14 problem -- did Your Honor get a chance to even look at the  
15 letter?

16 THE COURT: I have looked at the letter.

17 MR. BERNICK: Yes. There have been more developments  
18 since last night when I sent that letter at 11:15 and I went  
19 back to my room to start to work on my witnesses for today.  
20 First we received at 1:00 o'clock in the morning a whole  
21 package of materials relating to Doctor Harris who is sitting  
22 here in court today. This package of materials is  
23 substantial. I don't have -- it's a substantial collection of  
24 additional materials. It includes some demonstratives that  
25 were used on cross-examination of Doctor Wecker which I

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1 understand. It includes a whole new series of computer  
2 programs, all of which apparently are designed to be presented  
3 this morning.

4 Moreover, we analyzed the computer disks to the  
5 extent that we could. We had people working around the clock  
6 last night to come to even the vaguest understanding of what's  
7 there.

8 Doctor Wecker is available to speak to the Court  
9 right now by telephone and explain to the Court the volume of  
10 new work that's been done, and that work is very substantial.

11 I would feel more comfortable in discussing this if  
12 Doctor Harris, who is sitting there, would leave the courtroom  
13 because I may have to examine him.

14 THE COURT: Doctor Harris, please leave.

15 MR. STENGEL: Excuse us, please.

16 (Doctor Harris leaves courtroom.)

17 MR. BERNICK: I know that Doctor Wecker can explain  
18 it more adequately than I can. But we have been through this  
19 process with Doctor Harris before. This happened -- this is  
20 exactly a replay of what happened with the Selikoff data this  
21 last summer where the data came in. He was busy working on  
22 it, round-the-clock. Showed up at his deposition bleary  
23 eyed. He spent literally thirty days working on a whole new  
24 report, never told anybody about it. Until -- until our  
25 experts had gone ahead and done what they had to do. He came

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1 out with report number six and Magistrate Judge Gold struck  
2 the whole thing.

3 Your Honor reversed that because the trial date  
4 slipped.

5 It looks like the same thing has been done. He's now  
6 got a whole new series of calculations relating to the quit

7 dates which are so critical. He's got at least four new  
8 calculations. He relies upon new data inputs, not the  
9 original Rabinovitz data inputs, new data inputs.

10 So we have a whole new show that they are trying to  
11 introduce at this late date. It is an outrage to the Court.  
12 It is an outrage to the parties. It is absolutely  
13 intolerable. I can't understand how counsel for the Trust can  
14 countenance the submission of this data. I have never  
15 observed anything that comes close to this kind of thing, to  
16 say nothing before a court of such high regard as Your Honor.  
17 It is absolutely amazing to me.

18 If you call Doctor Wecker, he can tell you in more  
19 detail. There is no way that it is humanly possible for us to  
20 deal with this data in the context of this trial much less to  
21 have this data in this submission come forth with any notion  
22 of fair process in this trial.

23 We would move the Court to strike the testimony of  
24 Doctor Harris in its entirety. We believe that this is a  
25 totally improper move. Doctor Harris should not be permitted

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1 to take the stand. He should not be permitted to utter a word  
2 in light of what he's done here. Again, if Your Honor wants  
3 more details, we have to make a formal proffer, we will.  
4 Doctor Wecker is available by phone and I have his telephone  
5 number for the Court if you wish to call.

6 THE COURT: Well, consult with your colleague on the  
7 plaintiffs' side. I am not going to allow this witness to  
8 introduce new data.

9 MR. STENGEL: Your Honor, just so the record is  
10 clear --

11 THE COURT: I mean, he can reanalyze the other data.

12 MR. STENGEL: That's exactly what -- Your Honor, just  
13 so the record is clear, what he is going to respond to, first  
14 Your Honor may recall that when I was crossing Doctor Wecker,  
15 he took the position that he had done several other CPS II  
16 comparisons other than the asbestos only. We hadn't seen  
17 those. They weren't in the materials we had received.  
18 Doctor Harris went back to the existing data to see what had  
19 been done. Over the lunch hour, as you recall at a break in  
20 cross, Doctor Wecker did a new CPS II comparison, made the  
21 difference we found disappear. We have looked at that,  
22 because Doctor Harris needs to respond. As Your Honor knows,  
23 some very substantial allegations essentially of scientific  
24 misconduct were made through Doctor Wecker's testimony.

25 As to the selection of medical to medical data or POC

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1 to POC data, Doctor Harris, as was I, was surprised by the  
2 answers given by Doctor Wecker as to whether stop date meant  
3 stop date or something else. He told me on cross, he  
4 equivocated, it means well, maybe something else. That meant  
5 we had to look and get under the data. One of the problems  
6 with crossing experts on this material, as Your Honor is  
7 aware, is that it's very hard for lawyers let alone the jury  
8 to understand what's at issue.

9 This witness has given testimony --

10 THE COURT: Is he using new data or is he not?

11 MR. STENGEL: He is not using any data which have not  
12 been in the hands of the defendants for six months.

13 MR. BERNICK: He's using new data. He's not using  
14 the extract. He's using some other raw data sources.

15 THE COURT: Excuse me.

16 MR. STENGEL: Your Honor, it may be more efficient  
17 just to have Doctor Harris explain to the Court what exactly  
18 he's doing.

19 THE COURT: We will do that outside the presence of  
20 the jury.

21 MR. STENGEL: Yes.

22 MR. BERNICK: Before that happens, Your Honor, in  
23 order for that to be informed, I would appreciate it if Your  
24 Honor would call Doctor Wecker. I believe that it would  
25 significantly inform the process of eliciting information from

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1 Doctor Harris.

2 THE COURT: All right. He will listen to  
3 Doctor Harris testify. Call -- I have another motion for a  
4 moment.

5 (Recess taken.)

6 THE COURT: All right. Would you get Doctor Wecker  
7 on the phone and ask Harris to come in, please.

8 You have twenty minutes to resolve whatever you are  
9 going to resolve. The jury is coming in at 10:00 o'clock.

10 Good morning, doctor, you are still under oath.

11 THE WITNESS: Thank you.

12 J E F F R E Y H A R R I S ,  
13 called as a witness, having been previously duly  
14 sworn, was examined and testified as follows:

15 (Telephone call placed.)

16 MR. BERNICK: Doctor Wecker, we are in a courtroom  
17 full of people. Doctor Harris is on the stand. I have told  
18 the Court some of the circumstances surrounding our receipt of  
19 the computer disk and for the Court's information, have you  
20 had the opportunity to do a very brief review of those  
21 computer disks?

22 DOCTOR WECKER: Yes.

23 MR. BERNICK: Okay. I think that the Court is going  
24 to take some testimony from Doctor Harris so you have the  
25 opportunity to listen and maybe to make some comments after

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1 Doctor Harris testifies to the Court.

2 THE COURT: All right. If you can't hear, let us  
3 know and we will have people stand closer to the microphone.

4 Keep your voices up.

5 Proceed.

6 DIRECT EXAMINATION

7 BY MR. STENGEL:

8 Q. Doctor Harris, the issue before us right now is to what  
9 extent you use new data or information to respond to the  
10 criticisms that Doctor Wecker raised in his testimony of  
11 earlier this week. I guess the most efficient way to deal  
12 with this for the information of the Court is -- I am correct,  
13 that there are basically three criticisms you are responding  
14 to, the first is the CPS II comparison, the second is the  
15 selection of POC versus medical record quit date, and the  
16 third being the '63 break point and the interpretation of the  
17 scatter plot of claimant versus insulator quit rates?

18 A. That is correct.

19 Can you hear me? Doctor Wecker?

20 DOCTOR WECKER: Yes.

21 THE WITNESS: Thank you.

22 Q. If you could, Doctor Harris, focusing on what you have  
23 done analytically more than your conclusions, could you  
24 describe for the Court what you did -- strike that.

25 To what were you responding with respect to the

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1 CPS II analysis? What had Doctor Wecker done that you felt  
2 required a response?

3 A. I analyzed the data that Doctor Wecker had supplied in  
4 connection with his comparison of the Doctor Selikoff  
5 insulators with the men who participated in the CPS II study.  
6 My analysis was based on the data from the insulators which we  
7 both had in our possession, and the data that Doctor Wecker  
8 had supplied in connection with his analysis of the CPS II.

9 In addition, I also analyzed a computer run which was  
10 provided after lunch during the day of his direct testimony  
11 which he supplied.

12 I did not come up with or produce any new data from  
13 the CPS II or from the insulators or any other source in  
14 connection with that question which was not already in Doctor  
15 Wecker's possession or in the possession of the defendants.

16 Q. With respect to his -- we will call at this point  
17 lunchtime run for now, when did you actually get the data that  
18 he used to support that presentation?

19 A. Yesterday at about noon.

20 Q. All right. Let's turn to the issue of medical record  
21 quit dates versus POC quit dates.

22 Doctor Wecker made some fairly strong assertions with  
23 respect to your analytical work. Describe for the Court,  
24 again focusing more on the methodology and data than your  
25 ultimate conclusions, what you did with respect to those

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1 assertions of Doctor Wecker?

2 A. One of Doctor Wecker's concerns is that I misinterpreted  
3 the summary data that were provided from the medical audit  
4 that we all had in our possession more than a year ago. To  
5 resolve any such concerns, I looked at the raw data that was  
6 produced on each and every record, to see whether there was  
7 any missing information about quitting in the medical record.  
8 That raw data was also in the possession of all the parties,  
9 to the best of my understanding, more than a year ago, and  
10 when I went back in response to Doctor Wecker's concerns, I  
11 looked at that raw data to see in fact if I had missed  
12 anything.

13 Q. Was --

14 A. Beyond that, I know of no new data that I have analyzed  
15 that came from the audit, from any other source, that wasn't  
16 already in the possession, at least to my understanding, of  
17 all the parties more than a year ago.

18 Q. Now, was that inquiry prompted in part by a response by  
19 Doctor Wecker to my questions about exactly how he was  
20 treating stop dates out of medical records?

21 A. That is correct.

22 Q. That was given during his cross-examination yesterday or  
23 the day before?

24 A. That's my understanding, yes.

25 Q. All right. Let's turn to the third issue, which is the

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1 scatter plot of the claimants versus the insulators.

2 Do you have that question sufficiently in mind?

3 A. You mean, the pre-'63 versus the post-'63?

4 Q. That is correct.

5 A. Yes, I understand.

6 Q. You understood that that at least a chart reflecting that

7 data output was presented in court during Doctor Wecker's  
8 cross?  
9 A. Yes, I do.  
10 Q. Could you describe to the judge what, if anything, you  
11 did analyzing that data over the last few days and what data  
12 sources you employed?  
13 A. Doctor Wecker did a comparison of the quit rates of the  
14 insulators versus the claimants pre-'63, pre-1963 as well as  
15 post-1963. I showed the results of that analysis not in a  
16 summary statistical form but on a year by year basis, and in  
17 doing so I used absolutely no new data. I simply rerendered  
18 the same analysis in raw form rather than in summary form.  
19 Q. Going back to the CPS II analysis, we talked about the  
20 lunchtime runs. Were there other analyses or comparisons that  
21 Doctor Wecker referred to in terms of how he had looked for  
22 comparables by way of controlling for education and  
23 occupational group that you had not seen prior?  
24 A. If I understand Doctor Wecker's direct testimony  
25 correctly, he testified that he had run other comparisons

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1 between the insulators and the men who participated in the  
2 cancer society study. However, in looking at all of the  
3 disks, all of the computer materials that Doctor Wecker had  
4 supplied to me over the past year, up until the lunchtime run,  
5 there was only one analysis of the insulators versus the  
6 CPS II that I could find, and that was the one that he  
7 presented on his direct testimony.

8 MR. STENGEL: Nothing further, Your Honor.

9 THE COURT: All right. Cross.

10 CROSS-EXAMINATION

11 BY MR. BERNICK:

12 Q. Doctor Harris, with respect to the CPS II rerun that you  
13 did, is it true that Doctor Wecker's original report in the  
14 case he did the comparison between the insulators and CPS II  
15 and set forth the results in his report?

16 A. Yes. As I understand it, you can't tell whether it was  
17 his original report or his supplement --

18 Q. Yes or no would be terrific, Doctor Harris. Did he do  
19 that in his report?

20 A. He did it in one of his reports, yes.

21 Q. Was his report filed in June of this last year?

22 A. A supplement was in October 17. No. I am going to give  
23 a longer answer, if I may.

24 The actual CPS II data that he supplied that I could  
25 use in order to examine his results was not supplied to me

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1 until November the 6th.

2 Q. In his report in June, did he present a comparison  
3 between the CPS II data and the insulators and produce a curve  
4 reflecting the results?

5 A. Yes, he did. In one of his reports.

6 Q. Was that exactly the same curve that he -- was that  
7 exactly the same curve that he displayed to the Court in the  
8 direct examination in this trial?

9 A. I believe the curve that, or the results that he  
10 displayed to the Court were the results produced in his  
11 October 17 supplement.

12 Q. Do you recall that he was also deposed on exactly the  
13 same subject?

14 A. Yes.

15 Q. So both the curve and the fact of the significance of the

16 curve was available to you through Doctor Wecker's work  
17 substantially before this trial began, is that correct?  
18 A. I think it would be fair to say that all of Doctor  
19 Wecker's work including the materials he relied on were  
20 available to me from approximately November the 6th on.  
21 Q. In point of fact, what was new at the trial was that a  
22 plaintiffs' exhibit was introduced, Plaintiffs' Exhibit Wecker  
23 number 11, which showed a difference between CPS II and the  
24 insulators. Correct?  
25 A. That's correct.

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1 Q. This is a curve that you generated, correct?  
2 A. That is correct.  
3 Q. When did you generate this curve?  
4 A. About a week ago.  
5 Q. About a week ago. Even before Doctor Wecker testified,  
6 correct?  
7 A. I gave the --  
8 Q. Was it before -- was --  
9 A. It was before Doctor Wecker testified. It could have  
10 been less than a week ago. It could have been a few days ago.  
11 Q. It was before Doctor Wecker testified; is that correct?  
12 A. I think so. I could tell you exactly by looking at the  
13 date time stamp.  
14 Q. Who asked you to make this?  
15 A. Who asked me to make this?  
16 Q. Yes. Who asked to you to do the graph?  
17 A. I did it myself. Nobody asked me.  
18 Q. You just did it on your own?  
19 A. Yes. That's -- that's my graph. Nobody said go do that.  
20 Q. The data to support this graph was not supplied to us  
21 until the lunch hour after the graph was used with Doctor  
22 Wecker, correct?  
23 A. No. The data on which that relies on you had all along.  
24 Q. No. The program run, Doctor Harris, the program run to  
25 support this graph was given to us during the lunch hour,

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1 correct?  
2 A. That I don't know. I wasn't here.  
3 Q. When you say the new run that was done by Doctor Wecker  
4 during the course of his redirect examination, that was a run  
5 that was done in response to the new graph that was used on  
6 cross-examination, correct?  
7 A. That you would know. I wouldn't.  
8 Q. Let's talk about the -- let's talk about the proof of  
9 claim data. Also with respect to the proof of claim data,  
10 Doctor Wecker's reports have said since day one that he had a  
11 criticism of how you determined the quit rates based upon the  
12 proof of claim, correct?  
13 A. Correct.  
14 Q. In fact, in your deposition you were deposed on exactly  
15 that very same subject, were you not?  
16 A. Correct.  
17 Q. On direct examination he made exactly the same point  
18 about the proof of claim that he did in his report, correct?  
19 A. Correct.  
20 Q. Okay. Now, you say that you have not -- you were careful  
21 when you talked about CPS II, the CPS II work that you have  
22 now done you say is based upon the same data that Doctor  
23 Wecker used; is that correct?  
24 A. That's correct, yes.

25 Q. By contrast, the proof of claim work that you do is based  
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1 on what you now call raw data, correct?

2 A. Yes. That's correct.

3 Q. Isn't it true that the proof of claim program that you  
4 ran that supports the model that was presented to this jury is  
5 not based upon that raw data? It is based upon a different  
6 data -- set of data, a different extract, true?

7 A. Correct.

8 Q. Okay. Is it also true that you have never, ever produced  
9 to us any computer runs for purposes of your model that have  
10 been based upon this new raw data that you have now worked on  
11 and given us computer disks on, is that correct?

12 A. That's correct. That is the raw data rather than the  
13 summary.

14 Q. When it comes to the '63 jump, the '63 jump, the '63 jump  
15 itself was also a matter that was criticized in Doctor  
16 Wecker's report, is that correct?

17 A. Yes.

18 Q. It was a matter that was discussed with him in his  
19 deposition, correct?

20 A. Correct.

21 Q. As well on that point his direct examination simply  
22 pursued exactly the same matters that were in his report,  
23 correct?

24 A. Correct.

25 Q. Okay. The year by year analysis, you say you have done

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1 year by year analysis of that data, correct?

2 A. Correct.

3 Q. Isn't it true that you specifically told us in your  
4 deposition under oath that the insulator data was not  
5 sufficiently robust to permit a year by year analysis?

6 A. I -- yes, but for a different purpose. That is, a  
7 one-year versus the other year. But that's not what I am  
8 doing. I need to give more than a yes or no answer to that,  
9 sir.

10 Q. You told us that the data set was not sufficiently robust  
11 to do year by year analysis, isn't that what you said in your  
12 deposition?

13 A. Year -- when year by year analysis means deciding whether  
14 the insulators quit rate in 1962 was any different than in  
15 1963, no, one couldn't do that. But to decide whether the  
16 pre-'63 quit rates as a whole are different than the post-'63  
17 quit rates, then in fact elucidating the raw individual data  
18 only helps.

19 Q. Representation was made to us by counsel when this graph,  
20 Plaintiffs' Wecker Exhibit 11 was produced, a representation  
21 was made that the -- a hard copy was given to us and the  
22 representation was made that the hard copy of the program  
23 supported this graph. Were you aware of that?

24 A. I supplied all of the materials that I used to generate  
25 the graph. That's all I could tell you.

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1 Q. You don't know what hard copy was furnished to us during  
2 the lunch hour or whether it matched the computer disk we were  
3 provided?

4 A. I don't know what you were supplied, sir.

5 Q. Okay. With all these calculations that you have now done  
6 on the proof of claim, you have not only used raw data, you



7 have run a whole new series of programs, correct?  
8 A. I have run programs that you haven't seen. There are  
9 variations of previously supplied programs.  
10 Q. Programs that we have not seen.  
11 A. Correct.  
12 Q. How many programs have you run to determine the quit rate  
13 of the claimants versus the insulators, how many programs have  
14 you run that have not been disclosed to us?  
15 A. None.  
16 Q. None?  
17 A. None. Every program I have run, you have.  
18 Q. Including the one that was sent to us last night?  
19 A. Correct, yes.  
20 Q. Okay. In that new set of programs, how many new programs  
21 have you developed and sent to us last night?  
22 A. Basically there is one program that I broke up into six  
23 pieces. But it is one.  
24 Q. One program, six different runs?  
25 A. No. You have -- I tend to write programs and break it

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1 down into pieces so that if there is a mistake along the way,  
2 it doesn't propagate. But it is one -- basically one  
3 analysis.  
4 Q. Isn't it true that you have developed not one new quit  
5 rate difference but three new quit rate differences that we  
6 have never seen before?  
7 A. No. The answer is, there is one quit rate difference and  
8 then there are what I would call sensitivity analysis to show  
9 what would happen if you did something in the extreme.  
10 Q. Tell me, sensitivity analysis, not sensitivity analysis,  
11 tell me how many different new quit rates come out of the  
12 computer program that you supplied last night?  
13 A. Four.  
14 Q. Four.  
15 A. Let's see, one, two, three, four. Four all together if  
16 you count everything as a possibility.  
17 THE COURT: All right. Stop.  
18 You've got five minutes. Did you want your witness?  
19 MR. BERNICK: I want to have my expert be able to  
20 comment to the Court.  
21 THE COURT: All right. Have him comment.  
22 MR. BERNICK: Doctor Wecker, if you could just  
23 describe for us the magnitude of the new information that you  
24 have received and also describe for us the -- the amount of  
25 work that would be necessary to prepare for an examination of

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1 Doctor Harris with respect to the information that you have  
2 received.  
3 DOCTOR WECKER: Okay. There are nine new programs  
4 involving hundreds of lines of code that I have not seen  
5 before and which are not simple modifications of a previous  
6 program. I know this because I have put them through a red  
7 line program trying to find something similar and I have  
8 nothing similar. They involve four new approaches and four  
9 new calculations that lead to four different quit rate  
10 comparisons. They involve a new, I understand now being  
11 called raw data set as an input that was not provided. That  
12 data set that was described by Doctor Harris as in the  
13 possession of all parties to the best of his understanding was  
14 not provided, has never been provided by Doctor Harris or  
15 anyone else to us.

16           So the first thing I would need to do to begin to  
17 analyze this is get them to be cooperative in providing that  
18 data set. I would then have to understand what that data is,  
19 what it means, how it was collected, what a proper  
20 understanding of it is, figure out what the choices were that  
21 were made by Doctor Harris and why perhaps with some  
22 motivation he's making this so I can understand what he is  
23 doing. I would hope that would mean we could get a deposition  
24 on that subject.

25           The total amount of time that I would estimate to do

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1   this would, with good cooperation, would be about a month's  
2 work with six to ten people.

3           MR. BERNICK: Just to give the Court a flavor for  
4 that, have we been through this process before with  
5 Doctor Harris?

6           DOCTOR WECKER: Yes. We have been through a total of  
7 seven different reports. Each making changes to the one  
8 before. So I have had some experience of how long it takes to  
9 get to the bottom of these rather intricate calculations.

10          THE COURT: All right. Thank you, doctor.

11          I don't want any new data based upon an analysis of  
12 the raw data. Anything else is okay. You can't go back to  
13 the raw data because you didn't rely on that up until this  
14 date. Right?

15          THE WITNESS: That is correct.

16          THE COURT: Okay. That's the way it will be.  
17 Anything else you can testify to.

18          If you want to bring in a defendants' witness  
19 Tuesday, I will hear him.

20          MR. BERNICK: Here is what I would propose, Your  
21 Honor, to move along. There is no way, given whether new data  
22 or not that I can pursue CPS II or the pre- or post-'63 in a  
23 meaningful way. I have just received this information last  
24 night. What I would propose -- what I would propose is that  
25 we proceed with the witnesses that we intended to proceed

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1   with. If they want to call Doctor Harris to pursue those two  
2 items next Tuesday, they can do it. We will respond next  
3 Tuesday and that will be it. It will be a traditional --

4          THE COURT: I would think it would be better since he  
5 is here to have him testify on direct and then you can  
6 cross-examine as you wish Tuesday.

7          MR. BERNICK: But that all just means, amounts to the  
8 same thing. The effects of that really is that it's on our  
9 nickel. The jury is going to be blaming us this afternoon for  
10 not finishing.

11          THE COURT: No. They won't. They will blame me. I  
12 will take the blame. They believe me when I say it is my  
13 fault. If you don't want to do it, it gives you the weekend  
14 to go over and you've got him with some firm direct.

15          (Continued on the next page.)

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1 MR. BERNICK: I understand that. I think I  
2 understand what the court is saying. I think that the proper  
3 way to do it, given what has taken place -- I don't want the  
4 jury to get his direct examination and then all of a sudden we  
5 get to cross-examination --

6 THE COURT: You would want him brought in Tuesday?

7 MR. BERNICK: I want him brought in Tuesday as part  
8 of their rebuttal case.

9 THE COURT: Excuse me. Can you come in, Doctor, on  
10 Tuesday? I know you have other things.

11 THE WITNESS: I am available to the court, and I  
12 will make the changes. My conflict is my problem.

13 I do have a question, what it means to rely on the  
14 so-called raw data. If I'm stepping out of line, I won't ask  
15 it.

16 THE COURT: Not at all.

17 THE WITNESS: I'll be happy to testify about it.

18 THE COURT: Okay.

19 THE WITNESS: Dr. Wecker expressed a concern that I  
20 have misinterpreted the summary data on the medical record,  
21 which I regarded as the gold standard for determining who quit  
22 and who didn't in the claimants.

23 To attempt to resolve that, he ran a run in which he  
24 excluded from the medical record analysis anyone at all with  
25 what he regarded as an incomplete record.

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1 When I read the colloquy, or the question and answer,  
2 on his direct examination, he testified that he had excluded  
3 about a thousand records in doing so. In fact, it was 1,292 I  
4 intended to testify to.

5 You had asked him, in eliminating that more than a  
6 thousand, is there any reason why that population might be  
7 skewed? Those with your words. I intend to testify, if  
8 permitted, that the correct answer is absolutely yes. There  
9 is overwhelming evidence that the vast majority of those  
10 people eliminated in such an analysis were people that likely  
11 continued to smoke and that those who remained were quitters.

12 However, my conclusion that that is true is based not  
13 only on the summary information already there, but by my going  
14 absolutely back to all the information in the medical record  
15 to make sure.

16 THE COURT: Excuse me. That's okay, as long as  
17 there is no runs.

18 MR. BERNICK: Your Honor, that leaves us in an  
19 impossible situation.

20 THE COURT: Excuse me. Your witness made some  
21 statements there and he's entitled, isn't he, to meet them?

22 MR. BERNICK: Absolutely not --

23 THE COURT: Excuse me. It's 10:00 o'clock. I will  
24 take this up with you further later.

25 THE WITNESS: I'll be prepared to testify that

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1 looking at every source --

2 THE COURT: You be prepared to testify. Whether you  
3 will or not I'll have to discuss with you.

4 THE WITNESS: Thank you.

5 MR. STENGEL: I do want to clarify --

6 THE COURT: I don't want any clarification. Step

7 down, sir. 10:00 o'clock Monday.  
8 Bring in the jury. Have your next witness.  
9 (Witness excused.)  
10 MR. BERNICK: Do we have the new numbers?  
11 THE COURT: Dr. Harris, will you be available over  
12 the weekend for a deposition if they need something?  
13 Do you want a deposition, yes or no?  
14 MR. BERNICK: I do not want to put -- I do not want  
15 a deposition --  
16 THE COURT: Okay.  
17 MR. BERNICK: It puts me in a position --  
18 THE COURT: Excuse me. Bring in the jury.  
19 MR. BERNICK: What I would ask your Honor, instead  
20 of putting it to me like that, can we have over lunchtime or a  
21 break to take up the matter in due course?  
22 THE COURT: Yes.  
23 MR. BERNICK: Thank you. Remove this easel, please.  
24 (Jury present.)  
25 THE COURT: Please be seated everybody. Good

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1 morning.  
2 JURORS: Good morning.  
3 THE COURT: If I may have your attention.  
4 We will not finish the testimony today. We will  
5 finish it Tuesday, I hope; if not Tuesday, it will be  
6 Wednesday, not because of any failure on behalf of either of  
7 the counsel, all of the counsel, or of any of the witnesses,  
8 because of certain rulings that I have made while you were  
9 away. So any blame for further extension of the trial should  
10 be placed on the court.  
11 As a reward, you'll have your lunch supplied by the  
12 government today.  
13 Call the next witness.  
14 MR. BERNICK: We apologize to the court and the  
15 jury. I want to quickly make a transition here.  
16 (Pause.)  
17 MR. BERNICK: We will call Dr. Fred Dunbar to the  
18 stand.  
19 THE COURT: Good morning, Doctor. How are you?  
20 THE WITNESS: Good morning.  
21 THE COURT: You have testified before, haven't you,  
22 here?  
23 THE WITNESS: Yes, I have.  
24 THE COURT: You are still under oath.  
25

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1 F R E D E R I C K C. D U N B A R,  
2 called as a witness, having been previously duly  
3 sworn, was examined and testified as follows:  
4 DIRECT EXAMINATION  
5 BY MR. BERNICK:  
6 Q. Good morning, Dr. Dunbar.  
7 A. Good morning.  
8 MR. BERNICK: Good morning, ladies and gentlemen.  
9 JURORS: Good morning.  
10 Q. Dr. Dunbar, we're going to talk here today about whether  
11 the Manville Trust paid for tobacco.  
12 A. Yes.  
13 Q. Okay. Let's give the jury a little bit of introduction  
14 to you and your background. Could you tell us where it is  
15 that you work.

16 A. National Economic Research Associates.  
17 Q. And could you tell the jury basically what that  
18 organization is.  
19 A. It's a group of consulting economists. Most of us are  
20 former academics who, for one reason or another, like the  
21 life-style of consulting. There are about 400 people in 13  
22 offices worldwide.  
23 Q. What's your position there?  
24 A. Senior vice president.  
25 Q. Do you also have an adjunct professorship at Columbia

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1 University?  
2 A. Yes.  
3 Q. I would like to show a little chart to give the get the  
4 jury into your areas of expertise. Showing you DEM 12128.  
5 Does this reflect your areas of expertise?  
6 A. Yes, it does.  
7 Q. Could you just talk a little bit about what your  
8 background is in each one of these areas.  
9 A. Yes. In terms of my educational background, I went to  
10 college, where I majored in both mathematics and economics. I  
11 did that on scholarship and working in a plywood mill to pay  
12 the tuition.

13 From there I went to -- that college gave me a BA,  
14 and then I went to graduate school at Tufts University on a  
15 National Science Foundation grant, where I got an MA and a  
16 Ph.D., both in economics.

17 I taught there for awhile and then I went to help  
18 form a graduate school in economics at Northeastern  
19 University, and there I taught mainly the mathematical areas,  
20 such as he econometrics, statistics, mathematical economics.

21 I left there to pursue policy research, applying my  
22 statistical and economics background, and in 1979 I joined the  
23 firm of National Economic Research Associates.

24 We were purchased in 1983 by a firm called Marsh &  
25 McClennon, which had a business of providing advice to

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1 companies on risks, insurable risks, such as product liability  
2 or if somebody were to sue from falling down in the plant and  
3 breaking a leg, that sort of thing.

4 As a result of that, I was able to work with them and  
5 their clients in order to try to get a grip on what the future  
6 lawsuits against those companies would be in various areas.

7 We call that claims estimation, those are claims that  
8 are going to be made against a company. So I have been doing  
9 that for about the last seventeen years.

10 Q. Have you published articles in your field?

11 A. Yes. I have about twenty-five peer-reviewed articles and  
12 about fifty or sixty other items that appear in trade press or  
13 invited publications, and I have one book.

14 Q. We'll talk about the book in a moment. Have you taught  
15 statistics and economics?

16 A. Yes. That's what I taught at Tufts and Northeastern.

17 Q. Let's get to the book. I have -- it's not even out of  
18 the wrapping, Estimating Future Claims. Case Studies for Mass  
19 Tort and Product Liability.

20 Is this the book that you have written?

21 A. Yes, it is.

22 Q. You've mentioned the word estimation, claims estimation  
23 as one of the areas of expertise. I want to focus on that a  
24 little bit.

25 The jury has heard from statisticians, they have

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1 heard from economists, I don't believe they have heard from  
2 anybody who has practiced within the field of claims  
3 estimation. Could you tell us what it is that claims  
4 estimation involves.

5 A. Yes. Very often a company has produced a product which  
6 is going to create a problem for them. They may not know that  
7 in advance or they may know about it at some point when some  
8 lawsuits come in, and what the claims estimation does is it  
9 gets into determining -- it tries to answer the question of  
10 how many lawsuits are going to be filed against the company,  
11 and then what's going to be the cost of resolving those  
12 lawsuits, both in terms of litigation expenses and also in  
13 terms of the payments that the company is going to have to  
14 make to the plaintiffs who are suing them.

15 Claims estimation involves figuring out such things  
16 as the number of people who used or were exposed to the  
17 product, from those number of people, how many suffered some  
18 injuries, such as a health problem or a damage to their  
19 property, and then how many of those will make a claim --  
20 actually a relatively small percentage tend to make a  
21 claim -- once that claim is made, how is it going to be  
22 resolved -- will it go to trial? Will it be settled? -- and  
23 then how much is the company going to pay.

24 Q. Have you given seminars in the field of estimating  
25 claims?

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1 A. Yes, I have.

2 Q. The book, is that a book about the estimation of claims?

3 A. Yes, it is.

4 Q. Is DEM 012129 a list of claims facilities that you have  
5 analyzed during the course of your professional career?

6 MR. BERNICK: Sorry. Would it be possible, while we  
7 have the testimony going, if we could have a little bit less  
8 activity on the table here? I'm sorry.

9 Q. Dr. Dunbar, could you just go through the claims  
10 facilities that you have analyzed?

11 A. Yes. One way, established actually in this court on  
12 Agent Orange, I worked on the issue of who would be the best  
13 organization, the Aetna insurance Company, to manage the  
14 claims processing.

15 I worked on what has become known as the Center for  
16 Claims Resolution, which was a group of about twenty asbestos  
17 manufacturers who got together to sort of reduce the cost of  
18 managing asbestos exposure.

19 I have analyzed the breast implant, MDL,  
20 multi-district litigation. That was a facility developed by a  
21 court in Northern Alabama to deal with breast implants.

22 I have also had to analyze the Dalkon Shield Trust,  
23 which paid claims to women who were injured by the Dalkon  
24 shield device. And I have analyzed the claims and values for  
25 twelve asbestos manufacturers.

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1 Q. These are all situations in which it is the product that  
2 cause injury, the injury causes claims to be filed, and your  
3 role is to get involved in understanding what kinds of claims  
4 are being filed, the value of those claims, the future  
5 projections of those claims. Would that be a fair  
6 statement?

7 A. That's a very fair statement.  
8 Q. Okay. Let me take a look at other claims estimation  
9 work. DEM 012030. Are these other areas where you have done  
10 claims estimation work?  
11 A. Yes. DES was a product to prevent premature labor in  
12 women. It turned out to cause problems in babies. Chemical  
13 manufacturers often have a wide variety of products,  
14 everything from Saran Wrap to cement that might not work.  
15 I have estimated claims for air bags even before they  
16 were introduced because the manufacturer felt that there might  
17 be might be some future liability from air bags that didn't  
18 work and injured people.  
19 American Club is the group that insured the maritime  
20 industry, and they had to pay asbestos claims. H.K. Porter is  
21 an asbestos manufacturer. Hardboard siding was a product that  
22 kind of degraded in the rain, was not a very good idea in the  
23 Northeast and Southeast on houses.  
24 Synthetic stucco has basically the same problem,  
25 works very well in Las Vegas but not in the Southeast.

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1 Q. Let's talk about tobacco. Have you ever been retained to  
2 act as an expert witness in tobacco litigation?  
3 A. Other than this?  
4 Q. Yes.  
5 A. I am -- I have been retained in at least two other  
6 matters.  
7 Q. They are related to -- what period of time does that  
8 involve?  
9 A. Over the last year and a half.  
10 Q. The last year and a half. Is this the first time that  
11 you've testified in a case involving tobacco?  
12 A. In court, yes.  
13 Q. Let's go to some of the basic methods that you use in  
14 claims estimation.  
15 Is DEM 012131 a brief recitation of some of the  
16 methods that are involved?  
17 A. Yes, in fact this follows a fairly typical sequence that  
18 we would go through. Even though ultimately the work I do has  
19 to involve numbers because management really wants to know  
20 what the dollars and cents are for their future liabilities, I  
21 have to get an understanding that goes beyond that in the  
22 initial phase.

23 I have to understand the process at work. If it's a  
24 case of a medical problem, I have to get an understanding of  
25 what is called the epidemiology, and I have to get an

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1 understanding from the claims facility of how they go about  
2 handling these claims, how they deal with their adversarial  
3 relationship with the plaintiffs.  
4 So that causes a review of historical documents and,  
5 if I'm working for a firm, then I usually have extensive  
6 interviews with the legal staff, the claims handlers, maybe  
7 the technical people.  
8 In a case of litigation, sometimes I don't have  
9 access to the people who are involved in the facility because  
10 they are on the other side, so in that case I rely on  
11 deposition testimony, which is the lawyers ask the questions  
12 that I would like to have answered in a deposition, and then I  
13 review the deposition testimony.  
14 Data preparation means that we have to try to get  
15 ahold of a database. Now, if it's kind of a mature situation,

16 like asbestos is, there are a number of claims databases that  
17 give you good historical information and then you can use  
18 those historical experiments to tell you what's going to  
19 happen in the future. Sometimes the data are not as good as  
20 you want and you have to go outside that and acquire more  
21 information.

22 Then we get to the statistical analysis, and  
23 basically what the statistical analysis does is it kind of  
24 puts together the first two steps.

25 Step one tells me what I think the kind of

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1 relationships, the correlations and things that I want to test  
2 are, and then I have the data in step two, and then in step  
3 three, I actually test what my beliefs are on the basis of  
4 reading the documents or talking to people, and I find out  
5 whether some relationships are reliable or unreliable, and I  
6 find out whether some things that I thought were reasonable  
7 are unreasonable and, ultimately I hope to be able to quantify  
8 these things so I can end up giving a dollars and cents answer  
9 to the client.

10 Then the last step is, once I have kind of a handle  
11 on what I think the correlations are, what I think these  
12 relationships are, I can make estimates based on other events  
13 happening, such as inflation or whatever is going on.

14 I'll try to estimate into the future what the  
15 situation will be or I'll try to make an estimate for  
16 management of what would have happened in the past had they  
17 pursued a different strategy, had they done something  
18 different, what would their exposure have been. So that helps  
19 them understand what they should be doing in the future.

20 MR. BERNICK: Your Honor, we would offer Dr. Dunbar  
21 as an expert in claims analysis and estimation.

22 THE COURT: He may give his opinion.

23 Q. Dr. Dunbar, again, in the same type of fashion, does DEM  
24 012132 outline in general terms the tasks that you performed  
25 for this particular case?

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1 A. Yes. We had access to a lot of documents and deposition  
2 testimony, in the first instance. In the second instance, we  
3 had available to us the databases that the plaintiffs used,  
4 which were claims, samples of the claims that had been filed  
5 against the Trust, and also we had what was called the full  
6 extract, which is a database that has all of the Trust claims  
7 on it.

8 We were able, also, to get data out of files that the  
9 Trust had made, where there were notes about the settlement  
10 negotiations that they were going through with the plaintiffs'  
11 attorneys.

12 So those provided the primary sources of data. Then  
13 I did the statistical analysis to find out what was causing  
14 the money per claim that the Trust was paying. Then finally I  
15 was asked to look and see what would happen if there had been  
16 less smoking on those filings.

17 Q. To put it in kind of simple terms, you have a lot of  
18 quantitative analysis, statistical analysis, you got a lot of  
19 history.

20 Have you done your best to literally relearn the  
21 history of how the Trust operated in order to understand why  
22 it paid the money that it did?

23 A. Yes. Like I say, we were fortunate in that the Trust had  
24 a lot of documents that we could review for them.



25 Q. Okay. The jury has heard about the contribution of  
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1 tobacco to asbestos-related illness, that asbestos-related  
2 illness is caused in part by smoking.

3 Have you looked back to determine whether in settling  
4 claims the Manville Trust as well as others sought to take a  
5 discount or reduce the settlement value so that they wouldn't  
6 pay for tobacco, have you looked into that?

7 A. Yes, I did.

8 Q. What have you found, just in general terms, was there or  
9 was there not an effort by the Trust and indeed others before  
10 them to reduce the settlement of claims being brought by  
11 smokers so that they wouldn't be paying for tobacco?

12 A. Yes. The Trust and asbestos manufacturers did try to  
13 reduce the amount that they would pay to a smoker because of  
14 the effect of smoking on the plaintiff.

15 Q. How far back -- we know that the Trust came into  
16 existence in 1988. Is there a term we can use just a  
17 shorthand term that we can use to talk about this reduction in  
18 settlements so that you don't pay for tobacco?

19 A. The Trust term is shared causation.

20 Q. Shared causation. We often talked about it in terms of  
21 being a tobacco discount, or something to that effect?

22 A. Yes.

23 Q. Do you see that in the testimony of the witnesses as  
24 well, that they talk about tobacco discount?

25 A. Right.

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1 Q. Even before the Trust came into existence, was there a  
2 practice of discounting claims by reason of tobacco?

3 A. Yes. The asbestos manufacturers were very conscious of  
4 the defenses that they had, which included smoking, and so in  
5 terms of the litigation value of a claim, a claimant who was a  
6 heavy smoker had kind of a harder road to hoe in litigation  
7 than a claimant, say, who was a nonsmoker.

8 So from the -- even from the seventies, when there  
9 was litigation, there was a discount for smoking that occurred  
10 in settlements to reflect what would happen if the case went  
11 to trial, and people started writing about that discount as  
12 early as 1980.

13 Q. Okay. We're not going to go quite back that far. But  
14 have we prepared -- are you prepared to address this tobacco  
15 discount from -- within periods of time over history in order  
16 to explain how the discount came into the Trust and how it  
17 affects the payments the Trust is even making today?

18 A. Yes.

19 Q. Showing you DEM 012160 -- I'm going over here at my  
20 peril --, but we're not going to be making much use of the  
21 chart in detail except to create a point of reference.

22 Does this chart break out the basic periods of time  
23 during which tobacco discounting took place or was discussed?

24 A. Yes.

25 Q. Are we going to basically go through these basic periods  
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1 of time here this morning as efficiently as we can?

2 A. Yes.

3 Q. Okay. Let's talk about the period of time even before  
4 1985. Have you found evidence that there were proposals that  
5 were considered by the Johns Manville Corporation to take the  
6 total value of a settlement and divide it up between asbestos,

7 on the one hand, and tobacco on the other?  
8 A. Yes. It was actively discussed and written on during the  
9 bankruptcy proceeding. There was a proposal made in  
10 bankruptcy, and some of the details of that proposal were  
11 eventually published in the literature.

12 Q. Showing you ARF 001170, -- which is already in evidence,  
13 your Honor -- is this an article that was written and  
14 published by people from Johns Manville, basically talking  
15 about a way to apportion settlements to asbestos versus  
16 tobacco so that the tobacco portion would not be paid by  
17 Manville?

18 A. Yes. This came directly out of the bankruptcy  
19 negotiations that were going on.

20 Q. Let me talk about this just in general terms for a moment  
21 to give the jury a feel for different ways that this might be  
22 done.

23 We have heard testimony that if you take the total  
24 risk of asbestos-related illness -- I will call this whole pie  
25 as risk -- some substantial part of it is -- pick any one you  
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1 want, say tobacco and asbestos -- some numbers created by the  
2 asbestos, some created by the tobacco, and there are some that  
3 is synergy, there has been testimony to that effect.

4 A. Yes.

5 Q. Is it possible, if you wanted to, to take the total value  
6 of a settlement and kind of divide the settlement dollars up  
7 by risk, if you wanted to do that?

8 A. Yes, it is.

9 Q. The approach that is described by Manville in the  
10 mid-1980's, is this an approach that is based in part upon the  
11 idea of allocating risk?

12 A. I think it's almost entirely based on risk, yes.

13 Q. There are some other considerations, the timing, whether  
14 it was pre or post warnings, things of that nature --

15 A. Because those things affect risk.

16 Q. Because those things affect risk?

17 A. Yes.

18 Q. Is it fair to say that the allocation or discounting  
19 method described here is a very complicated one?

20 A. This allocation method?

21 Q. Yes.

22 A. It is certainly something that is implemented. It's  
23 almost formulae.

24 Q. Is there a formula for it?

25 A. Yes.

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1 Q. So if you wanted to, you could take a formal formula and  
2 try to apply it?

3 A. That's correct.

4 Q. Could you also do this kind of allocation -- this  
5 allocation would result in a discount, wouldn't it?

6 A. Yes.

7 Q. That is, the asbestos company would pay this part, they  
8 wouldn't pay this part, they would pay less money?

9 A. That's correct.

10 Q. Is it also possible to do the same kind of allocation or  
11 discounting by negotiation?

12 A. Yes.

13 Q. So you have a formula here, but you may do it by  
14 negotiation, too?

15 A. That's correct.

16 (Continued next page)

17  
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23  
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1 EXAMINATION CONTINUES

2 BY MR. BERNICK:

3 Q. Okay. Let's take the next period of time, which is the  
4 ACF. We have down here that the ACF predated the Trust, the  
5 Trust is 1988. That's not going to stay there very long.

6 The ACF existed prior to 1988. Could you tell the  
7 jury what the ACF was?

8 A. The ACF grew out of a negotiation that was held among  
9 most of the major but not all of the major asbestos  
10 manufacturers and a law professor at Yale called -- whose last  
11 name is Wellington. They came to terms among themselves and  
12 with the insurance companies for a way to deal with the  
13 lawsuits that were being made against them and that became  
14 known as the "Wellington Agreement."

15 Out of the Wellington Agreement came something that  
16 is called the "Asbestos Claims Facility," where the membership  
17 varied over time, but it usually it was in the high thirties,  
18 around forty members, and they would try to -- they would pool  
19 their resources in order to negotiate. The ACF would  
20 negotiate on behalf of all forty of them and then once it came  
21 to an agreement with an attorney as to what the -- should be  
22 paid to the asbestos claimants, the ACF would then divide up  
23 the money that had to be paid among the members, according to  
24 various formula.

25 So basically, they negotiated settlements with

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1 attorneys. They were in the tort system.

2 Q. Okay. So these are other manufacturers?

3 A. Yes.

4 Q. Other asbestos companies. And they are banding together,  
5 creating a facility and they settle a lot of claims?

6 A. Yes.

7 Q. This is all before the Trust even came into existence?

8 A. Yes.

9 Q. Do you know whether in the ACF, as the Asbestos Claims  
10 Facility settled cases, do you know whether they took a  
11 discount for tobacco?

12 A. They did.

13 Q. Are you familiar with the testimony of a Mr. Gregory  
14 Smith?

15 A. Yes, I am.

16 Q. Who is Gregory Smith?

17 A. Greg Smith was manager of the eastern region of the  
18 Manville Trust when they were negotiating claims in the preC  
19 and the post-C period.

20 He came to the Manville Trust from the ACF.

21 Q. Okay.

22 A. He was basically their chief negotiator for the eastern  
23 US.

24 Q. Did Mr. Smith also work not only for the -- I'm sorry.

25 He worked for the ACF as well?

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1 A. Yes.

2 Q. Okay. He then went over to become a worker for the  
3 Trust?

4 A. Yes.

5 Q. He testified in this case, is that right?

6 A. Yes.

7 Q. The jury will hear this testimony. Did he testify about  
8 taking a tobacco discount while he was with the ACF?

9 A. Yes, he did.

10 Q. Okay. Just to review briefly for the jury, this is page  
11 15, line 22.

12 You testified before that you looked at the smoking  
13 history of, I guess they would be plaintiffs who had made  
14 claims against the Asbestos Claims Facility. Was the purpose  
15 of looking at the smoking history to take a smoking discount  
16 for the people who were smokers?

17 Answer: Yes.

18 Describe what a smoke discount is.

19 Answer: Well, I think different people arrive at  
20 that in a different fashion.

21 We have talked a little bits about that, have we not?

22 A. Yes.

23 Q. But personally I would look at how many years they  
24 smoked, how many packs per day they smoked, how long they had  
25 been smoking, whether or not they had quit smoking and how

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1 long before that point in time they ceased smoking.

2 If I didn't mention it, what kind of cigarettes they  
3 smoked, whether they be filtered or unfiltered cigarettes,  
4 those sorts of factors.

5 Question, page twenty, line two: While you were with  
6 the Asbestos Claims Facility, did you take a smoking discount  
7 for lung cancer?

8 Answer: Yes.

9 Line 13: If a person was a current smoker and had  
10 lung cancer, would you take a smoking discount for that  
11 person?

12 Yes.

13 And I believe there is also testimony, was there not,  
14 regarding asbestosis?

15 A. Yes.

16 Q. Page 21, line two. Would you agree with me that there  
17 were circumstances where you would take a smoking discount for  
18 a person who had asbestosis?

19 Again his answer is yes.

20 Tell the jury why it is important to this case that  
21 the ACF took a smoking discount?

22 A. Yes.

23 In the -- what's called the preC period, the Trust  
24 had set out as its goal to settle seventeen thousand claims  
25 which were lawsuits that had been filed against Manville

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1 before the 1982 bankruptcy. The Trust wanted to settle those  
2 claims before what was a called the consummation date of the  
3 bankruptcy in November of 1988.

4 They started negotiating those claims, however, in  
5 May of 1988, giving them a period of only a few months in  
6 which to try to resolve what at that point was a fairly large

7 number of claims.  
8 Q. So we are now in the Trust era. The Trust doesn't open  
9 its doors until November of '89?  
10 A. '88.  
11 Q. '88. And during this initial period of time, they are  
12 trying to negotiate a bunch of settlements?  
13 A. That is correct.  
14 Q. Okay. I am sorry to interrupt.  
15 Continue.  
16 A. So they hit upon the idea of using the ACF settlements as  
17 a way to serve as a kind of a yardstick for how the Trust  
18 should compute its claim values. What they did is they said  
19 well, the ACF has been settling these claims for about three  
20 years before us. Most of these claims have been settled by  
21 the ACF already, and so we will take a share of what the ACF  
22 settlement was. A little more complicated than that, but  
23 basically that's it. They would take a proportion of the ACF  
24 settlement and use that to negotiate a settlement for the  
25 Manville claims.

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1 So what that meant was that if a smoking discount was  
2 given in the ACF, which it was, then that smoking discount  
3 would flow through to the negotiated Manville claim, because  
4 Manville is just taking a constant proportion of the claims,  
5 be it's a smoker or a non-smoker.  
6 Q. Okay. Before I ask you to explain that a little bit,  
7 again, did Mr. Smith, Mr. Smith used to work for the ACF, he  
8 came over to the Trust and did he -- was he one of the people  
9 principally responsible for settling claims in the preC period  
10 of time?  
11 A. Yes, he was.  
12 Q. Did he describe exactly what you have described, that is,  
13 the carry through of the tobacco discount to the preC  
14 settlements?  
15 A. Yes.  
16 Q. Showing you page 40, line one. Would you agree with me  
17 that by using the ACF data to determine the appropriate amount  
18 of payment to the claimants, that implicitly -- that  
19 implicitly a smoking discount was taken because the ACF had  
20 taken a smoking discount?  
21 Answer: If you're working from the same bottom line  
22 and in fact a smoking discount had been taken, it would have  
23 been taken into account, yes.  
24 Is that exactly what you have talked about here?  
25 A. Yes, it is.

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1 Q. Kind of put real simple, ACF terms a dollar figure for a  
2 claim. It takes off the top tobacco. That dollar figure  
3 carries over to the preC settlement of the Trust. What's  
4 happened to the tobacco dollars? Are they paid by the Trust  
5 or are they not paid by the Trust?  
6 A. No, they are not paid by the Trust.  
7 Q. Was that practice followed uniformly during the preC  
8 period of time?  
9 A. Yes.  
10 Q. Are we going to eventually get to a calculation of how  
11 much money was involved?  
12 A. Yes.  
13 Q. Okay. Let's talk about the post-C period of time.  
14 During the post-C period of time the Trust has now opened its  
15 doors. Let me ask you, how many claims were settled preC

16 approximately?  
17 A. In the fifteen thousand range.  
18 Q. Post-C period of time, trust now opens its doors and it  
19 starts to process claims on its own.

20 Is that fair?

21 A. Yes.

22 Q. During the post-C period of time, did the Trust follow  
23 the same practice, that is, to use the ACF prices or not?

24 A. No.

25 Q. Tell the jury what it is that the Trust did once it

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1 opened its doors.

2 A. What the jury did was evaluate each claim individually  
3 and they had people working in the claims facility who would  
4 look at the data and information that was provided by the  
5 plaintiffs' attorneys for each claimant, and they had at the  
6 end of the claim form a summary sheet where they would  
7 figure. They would work out the figures. Immediately try to  
8 figure out what they called the gross value of the claims,  
9 based on such things as lost compensation, pain and suffering,  
10 those things that go into what the value of the claim, and  
11 then they would take the next thing they would do after they  
12 figured out the gross value is they would take off a  
13 percentage for a smoker that they called "shared causation."

14 If a person smoked, they would take off 20, 50  
15 percent of the gross value before they would go down to  
16 figuring out the -- what the Manville recommended settlement  
17 number would be.

18 Q. Now, how many claims in total were being processed or  
19 were processed during the post-C period of time, do you  
20 recall, roughly?

21 A. Ten to twelve thousand.

22 Q. Ten to twelve thousand post-C claims?

23 A. Yes.

24 Q. To do an individual evaluation for ten to twelve thousand  
25 claims, would it be fair to say that you need a process for

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1 that?

2 A. Yes.

3 Q. The process that was followed, is that something that had  
4 to be pretty formal at the Trust?

5 A. It was written out. You could follow objectively what  
6 claims evaluator had done because they wrote out their  
7 thinking.

8 Q. So when you are here to talk to us about how a tobacco  
9 discount was taken, is that something that's actually written  
10 down?

11 A. Yes.

12 Q. Showing you GZ, G as in George, Z as in zebra, 200053,  
13 which is already in evidence. Is this the first page of the  
14 evaluation manual or form here? Instruction?

15 A. Yes.

16 Q. It stays the evaluation of a claim calls upon all of your  
17 training.

18 This is an instruction to the claims people?

19 A. Yes.

20 Q. All of your training, knowledge and experience and is the  
21 culmination of all the fact finding efforts on the case at  
22 hand. It is the place where all of the loose strings, various  
23 aspects and unique features of a claim are pulled together to  
24 form a cohesive and logical bird's eye view of the case to a

25 reserve at a reasonable dollar value for the claim.

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1 A procedures manual is not the forum to explain how  
2 to evaluate a case. That involves months and months of  
3 intense training and experience. It then goes on to talk  
4 about the fact that an example though is provided. It says on  
5 the following page is an example of the evaluation section of  
6 the CAS which may be useful to refer to as you read the  
7 following text.

8 We then have the next page as an example. I don't  
9 know if the jury can see. This is a case where you have a  
10 hundred pack year smoker with upper low -- upper lobe  
11 adenocarcinoma, ten years exposure to PCBs, only underlying  
12 disease is pleural plaques, and you then get a discussion, you  
13 get a whole bunch of lost wages, costs, and then a total, a  
14 gross settlement value. What was the gross settlements value?

15 A. Six hundred thousand dollars.

16 Q. That means that the whole claim is worth six hundred  
17 thousand?

18 A. Yes. In terms of damages to the claimant.

19 Q. So we have total value is six hundred thousand dollars.  
20 But it then says minus. Shared causation two hundred forty  
21 thousand. So we've got two hundred forty thousand of shared  
22 causation, and it also subextracts out 70 percent Manville.

23 Is that right?

24 A. Non-Manville.

25 Q. Actually, non-Manville.

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1 How is that -- this is the percentage of the  
2 deductions. So you've got two hundred forty thousand, two  
3 hundred fifty thousand, kind of the same amount. What does  
4 non-Manville mean?

5 A. After they have subtracted out the two hundred forty  
6 thousand, leaving about four hundred sixty thousand there,  
7 they then would take off another share for what they believe  
8 was the responsibility of other asbestos manufacturers. They  
9 would say that our, in this particular instance, our  
10 responsibility is only 30 percent and the other manufacturers'  
11 responsibility is 70 percent, so they then take 70 percent of  
12 that number I just gave, whatever it was, three hundred some  
13 odd thousand.

14 Q. Okay. So you have two hundred fifty-two comes out for  
15 basically other asbestos?

16 A. Correct.

17 Q. Then you have another deduction for other discounts it  
18 says PCBs?

19 A. Yes.

20 Q. That's kind of another sliver, for another factor that  
21 may be responsible, PCB's. What's left over is the  
22 recommended settlement for what?

23 A. Yes. They add in a little bit here for dependent.  
24 That's basically right.

25 Q. It is for Manville.

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1 A. Yes.

2 Q. The idea is you go through the total value of the claim.  
3 You then figure out, take out shared causation, take out  
4 non-Manville, take out special factors, and you are left with  
5 what the Trust is going to pay?

6 A. Correct.

7 Q. This shared causation, is the shared causation actually  
8 described?

9 A. Yes.

10 Q. Turning to another page of the document. It says next  
11 comes several deductions. Shared causation almost always  
12 refers to the smoking discount.

13 After reviewing the smoking history and considering  
14 its effect on the claimant's disability, the CSN should  
15 indicate the discount as a percentage. A smoking discount  
16 should be considered on every other type of claim. That is,  
17 aside from mesothelioma.

18 Is that right?

19 A. Correct.

20 Q. Okay. This process, the process that we have described  
21 in the document here, is this also -- was this also described  
22 by Mr. Smith in his deposition?

23 A. Yes.

24 Q. Did he say that this form was in fact followed?

25 A. Yes.

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1 Q. I'm sorry. I want to get the reference to the -- there  
2 is a reference to some notes and in talking about the amount  
3 of the discount, the question at line -- page 68, line ten, or  
4 actually, line 14: Do you see that it says that the range of  
5 discounts is 25 to 75 percent?

6 Answer: Yes, I see that.

7 Question: Is that consistent with your view of the  
8 range -- you see where it says -- is that consistent with your  
9 view of the range of a discount for a lung cancer?

10 Answer: That is consistent with the range that you  
11 would tell people to look at. It is not necessarily  
12 consistent with the actual discounts taken over a period of  
13 time.

14 Question: Do you have a view as to what the actual  
15 range of discounts were over a period of time?

16 He then says at page 69: The only thing I could say  
17 was probably somewhere within this range, but where, I don't  
18 know.

19 Are we going to find out where it actually was?

20 A. Yes.

21 Q. Okay. So Mr. Smith confirms that the discount was taken?

22 A. Yes.

23 Q. Have you actually looked at the claim forms themselves to  
24 see if the shared causation discount was taken?

25 A. Yes, I have.

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1 Q. Showing you GZ-200072. Is this a series of CAS forms  
2 that were actually filled out?

3 I will show you page 0020049. Is this an example of  
4 the filled out claim form?

5 A. Yes.

6 Q. You see you have the gross settlement value. That's just  
7 like that we talked about, six hundred thousand? This is two  
8 hundred fifty-eight?

9 It says minus shared causation. Here it is  
10 explicit. For example, smoking.

11 Does that again reflect there was a smoking discount?

12 A. Yes.

13 Q. Here is another one, page 0020054, again, is that another  
14 example?

15 A. Yes, it is.



16 Q. Page 0020059, another example?  
17 A. Yes.  
18 Q. They vary?  
19 A. They -- in this particular batch, they vary almost  
20 directly proportionate with the pack years.  
21 Q. Pack years. Pack years is basically a measure of how  
22 many packs people have smoked and over what period of time?  
23 A. Exactly. If you are a one pack a day smoker over twenty  
24 years, that would be twenty pack years.  
25 Q. Here the discount is 15 percent of the gross value.  
page 5741  
page 5742  
1 A. This might have been the hundred pack year.  
2 Q. The hundred pack year person. That's a very substantial  
3 discount?  
4 A. Yes.  
5 Q. Okay. Now, again, when the Trust decided to do these  
6 discounts on a case by case basis, if they wanted to, they  
7 could have used a risk-based formula, could they not?  
8 A. Yes.  
9 Q. Did the Trust choose to use some sophisticated  
10 statistical model or risk-based approach?  
11 A. No, not in this period.  
12 Q. Are you familiar with what Mr. Austern said was the  
13 reason why?  
14 A. No, I am not.  
15 Q. Okay. It was part of his testimony.  
16 Let's review this approach a little bit. This is  
17 DEM-012133. This is kind of a prettier version of I think  
18 what we have talked about here.  
19 I think we are going to try to get a different screen  
20 in here. It might be a little bit clearer. It is hard to  
21 read.  
22 Does this basically describe the big pieces of the  
23 puzzle in figuring out what it is that Manville Trust actually  
24 paid for?  
25 A. Yes.  
page 5742  
page 5743  
1 Q. You have talked about in your example here non-Manville  
2 asbestos. Did the Manville Trust take pains to avoid paying  
3 for the portion of the claim that was felt to be caused by  
4 somebody else's asbestos?  
5 A. Yes, it did.  
6 Q. Did the Manville Trust take pains to avoid paying for  
7 shared causation, including specifically tobacco?  
8 A. Yes.  
9 Q. What was the only portion of the total value that was  
10 actually paid by the Manville Trust during the pre- and post-C  
11 periods of time?  
12 A. That which was attributable only to Manville.  
13 Q. Let me show you testimony of doctor -- of Mr. Austern in  
14 this trial, at page 2201.  
15 Question, line ten: Isn't it true that the Trust  
16 also deducted from total value shared causation?  
17 Answer: It did.  
18 Question: Therefore, that the recommended, the  
19 recommended Manville trust settlement was what was left over  
20 at the end?  
21 Answer: Is that a question?  
22 Question: Yes.  
23 Answer: I am not sure I would describe it that way.  
24 What was left over at the end was a negotiation number.

25 I say fine.

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1 Isn't it a fact that shared causation was defined by  
2 the Trust's own documents to be tobacco?

3 Answer: That was certainly one of the shared  
4 causations and I have no doubt that you can show me a form  
5 that did just that.

6 Then at 2202, during the post-C period of time, the  
7 Trust deducted other asbestos, right?

8 Answer: Other asbestos companies' liabilities.  
9 Other companies and it also deducted tobacco, right?

10 Answer: As part of shared causation.

11 Is that consistent with your own view?

12 A. Yes, it is.

13 Q. I then asked him this, page 2205, your legal  
14 responsibility, as you understood it, as you told all of your  
15 people, was to exclude share causation, true or not?

16 Answer: If you could in the negotiations to that.

17 Is that consistent or inconsistent with your  
18 understanding of what actually occurred?

19 A. That's consistent.

20 MR. BERNICK: At this time, Your Honor, we would like  
21 to request for admission number 85.

22 THE COURT: Yes.

23 MR. BERNICK: In this case. This is a request for  
24 admission, where the defendants put a formal question to the  
25 Trust and the Trust answered it in this case.

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1 Requests for admission -- admit number 85.

2 Admit that the Trust is not empowered to pay anything  
3 more than Manville's liability for asbestos related injuries.

4 Do you see that?

5 A. Yes.

6 Q. It's admitted as the court that oversaw the bankruptcy  
7 determined.

8 Now, I asked Mr. Austern about this. I asked him  
9 well, the recommendation to take the discount, was it in fact  
10 taken?

11 I asked him that, 2237. As you sit here today, you  
12 don't know what portion of that recommended deduction in fact  
13 was taken by the Trust, do you?

14 Answer: No, I do not.

15 Have you, Doctor Dunbar, determined with respect to  
16 the recommended amount for discounts how much in fact was  
17 actually taken?

18 A. Yes, I have.

19 Q. Could you tell the jury how you have gone about doing  
20 that? I know you have done it in a couple of different ways.

21 A. First of all, in the statistical data that I had the  
22 Trust's own files, we had a sample that had been drawn by the  
23 plaintiffs and on that sample we had those claims analysis  
24 summaries that had those lines filled out on them, and then  
25 also in the time, if you read either the form or you went into

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1 the file, you would know the number of pack years or the  
2 duration of smoking if it was a smoker that the -- that was  
3 attributed to the claimant.

4 So the first thing we did is we tried to see if there  
5 was a correlation between the smoking which was reported and  
6 the shared causation which was computed, and we found a very

7 high correlation between pack years and the amount of the  
8 shared causation discount.

9 We also then went and just computed the average of  
10 what the smoking discount was off of those claims analysis  
11 summaries for both lung cancer and for asbestosis. In the  
12 case of lung cancer, that average was 26 percent; and in the  
13 case of asbestosis, the shared causation amount averaged 14  
14 percent.

15 We also took -- from the sample we computed an  
16 average for non-smokers that were also lung cancer claimants  
17 who had both a recommended amount and a paid amount on the  
18 form and we compared that to the average for smokers, and we  
19 did that because we found a document in the files where  
20 somebody had upon analyzing six thousand records recommended  
21 one hundred twenty thousand for non-smokers and seventy  
22 thousand for smokers. We came up with our smaller sample of  
23 about a hundred and eighteen thousand for non-smokers, and  
24 about seventy-two thousand for smokers.

25 That gave us comfort, that we had found something in

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1 the same range that had been found by another expert in  
2 another court proceeding using the Trust's data.

3 Another thing that we did was we said well, if you  
4 compare simple averages, one of the problems with that is you  
5 may be making apples versus oranges comparisons. Somebody --  
6 you may have a non-smoker, for example, who has a lot of  
7 dependents and you are comparing that to a smoker who has no  
8 dependents. The non-smoker could have higher values because  
9 they have dependents rather than because they are a  
10 non-smoker.

11 What we did was we tried to match claimants up  
12 against each other on like versus like categories. We call  
13 that a matched pair sample. We would match people up on law  
14 firm. They had to have the same law firm.

15 We matched them up on jurisdiction, from the same  
16 geographic area. They had to have negotiated within ten  
17 percent what the Manville share was for that person, and they  
18 were matched up on other issues -- disease, dependents, that  
19 sort of thing.

20 We found a statistically significant difference in  
21 that matched pair analysis between smokers and non-smokers for  
22 both lung cancer and asbestosis, and the difference in the  
23 medians that we found was similar to the averages that we were  
24 computing off of the CAS forms.

25 Q. With respect to lung cancer in particular, what did you

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1 determine, showing you DEM-012135 regarding the prices or the  
2 values that were paid for claims brought by non-smokers versus  
3 claims brought by smokers?

4 A. Yes. I mentioned before that there was this other expert  
5 who had been working in a prior proceeding around 1990,  
6 Mr. Peterson, and he found that a non-smoker, or he  
7 recommended on the basis of an analysis of six thousand claims  
8 that a non-smoker should be valued at one hundred twenty  
9 thousand for Manville and a smoker at seventy thousand, and  
10 when we did our own calculation from a sample of claims that  
11 had been drawn by the plaintiffs in this case, again, where we  
12 had both recommended and paid amounts, these are the averages  
13 that we found.

14 We found a hundred eighteen thousand five hundred for  
15 a non-smoker and seventy-two thousand five hundred

16 seventy-nine for a smoker, which was very close to the  
17 recommendations of Mr. Peterson.  
18 Q. Now, if you wanted -- if the trust wanted to avoid paying  
19 for tobacco, was it critical that they do it in this way or  
20 are there other ways to achieve the same basic result by  
21 aggregating the total amount and taking off an aggregate  
22 amount? Do you have to go this way or is this just one way of  
23 doing it?

24 A. This is just one way to do it.

25 Q. Have you determined on a percentage basis for lung cancer

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1 the portion of the total value during the pre-TDP period of  
2 time, the portion of the total value that was paid by  
3 Manville?

4 A. Yes.

5 (Continued on the next page.)

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1 Q. Do we have it here on this chart?

2 A. Yes, we do.

3 Q. During the pre-TDP period of time, did the Trust pay for  
4 anything other than the Manville Share?

5 A. Not that I could find out.

6 Q. During the pre-TDP period of time, did the Trust pay for  
7 shared causation for lung cancer?

8 A. It did not pay for that. It took that as a discount.

9 Q. With respect to asbestosis, showing you DEM 012136, is  
10 this the same basic type of chart for asbestosis?

11 A. Yes, it is.

12 Q. Now, let me deal with something that --

13 MR. BERNICK: After this may be a good time for a  
14 break, your Honor, we're going to go to another subject.

15 Q. One issue I want to take up, Dr. Dunbar, is a little bit  
16 tricky to deal with.

17 There has been a claim in this case, Mr. Austern has  
18 testified through deposition that the Trust knew even before  
19 it opened its doors that there were going to be more and more  
20 serious claims against the Trust, more and more serious claims  
21 because people smoked. I want you to assume that. It was  
22 shown to the jury yesterday. Mr. Austern and the Trust knew  
23 that.

24 So I want you to assume that there were more

25 claims -- I know you've done an analysis -- more people

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1 because they smoked got asbestos-related illness.

2 How could it be that if all the Trust did was to take  
3 a discount on each claim, how could it be that they wouldn't  
4 end up paying more because there are more claims?

5 Did I pose the question the right way?

6 A. That is in fact the very reason that they take the  
7 smoking discount. If you have a number of -- more claimants  
8 because they are sick from either asbestos or smoking or  
9 both,, you can't tell in any individual claimant whether that  
10 disease is due to asbestosis and give them a full value, and  
11 for the next person, whether that disease is just due to lung  
12 cancer and give them zero value. You just can't tell.  
13 Science doesn't allow you to do that.

14 So what you do is you give a discount to everybody so  
15 that the net amount of what you would be paying is the same as  
16 if you could tell with certainty which among that group was  
17 solely due to asbestosis and which among that group was solely  
18 due to tobacco.

19 Q. In that fashion, even if there were more claims due to  
20 tobacco, and in that you've got a whole analysis about whether  
21 that's true or not, even if there were, would the approach  
22 that the Trust took of discounting the claims of all smokers  
23 be an approach designed to recognize the fact that they are  
24 going to have more claims?

25 A. Yes. By taking the discount, they keep the aggregate

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1 dollars down to the level they would be if they could identify  
2 with total accuracy just those people who were sick because of  
3 asbestos.

4 Q. I have gone back to that same question I asked you  
5 before. If the Trust wanted to, could they have gone through  
6 this whole process of figuring out the percentages, figuring  
7 out the dollars, if they wanted to, could they have done it  
8 with a sophisticated risk allocation model, if they wanted to?

9 A. Yes.

10 Q. Did they decide to do that?

11 A. No.

12 Q. They decided to do it a different way?

13 A. That's correct.

14 Q. Is this the way that they decided to do it?

15 A. Yes.

16 MR. BERNICK: It would be a good time.

17 THE COURT: You want a break?

18 MR. BERNICK: Yes.

19 THE COURT: All right. Take a break.

20 (Jury leaves the courtroom.)

21 (Recess.)

22 (Jury present.)

23 THE COURT: Be seated. Yes, go ahead, please.

24 BY MR. BERNICK:

25 Q. Dr. Dunbar, before we go onto the next time period, I

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1 want to pick up one other part of your analysis for the Pre-C  
2 and Post-C period of time, which is an analysis relating to  
3 problems that the Trust had itself in its policies, practices  
4 and the plan.

5 There has been testimony and documents produced in  
6 this case that talk about problems that the Trust had with

7 administering the plan and its decision making. Are you  
8 familiar with those?  
9 A. Yes.  
10 Q. Have you reviewed those documents and have you reviewed  
11 the related testimony?  
12 A. Yes, I have.  
13 Q. And we're not going to go over all those documents and  
14 all that testimony here today. I just want to ask you, have  
15 you done some work to determine the impact of those kinds of  
16 factors, those kinds of problems on the Manville Share, that  
17 is the amount that the Manville Trust had to pay for  
18 Manville's own share, have you done that?  
19 A. Yes, I did.  
20 Q. Going back to GZ 20051, which is already in evidence, and  
21 directing your attention to page 505246. There's a discussion  
22 here about determining the Manville Share, and for the jury's  
23 benefit again, remember, is it true that during the Pre-C  
24 period of time that Manville Share was applied to the ACF  
25 prices?

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1 A. Yes, it was.  
2 Q. So the price was already set by the ACF, and the way that  
3 Manville determined how much to pay was that they used their  
4 share?  
5 A. Correct.  
6 Q. What was the estimated Manville Share that the Trust used  
7 in estimating the amount that it was going to have to pay?  
8 A. Ten to twenty percent of the gross amount of the claim.  
9 Q. And this is before they ever began to settle anything?  
10 A. Yes.  
11 Q. This was back in April of '88?  
12 A. Yes.  
13 Q. How have you used -- let me ask another question. When  
14 it actually came time to settle these Pre-C claims, these  
15 right here, was the ten to twenty percent simply always taken,  
16 that is whatever the ACF price was, it was ten to twenty  
17 percent, or was there some other approach that was used?  
18 A. Initially, the Trust tried to hold to the ten to twenty  
19 percent. They would come in to a negotiation with the  
20 plaintiffs' attorneys, saying, here's what we feel is fair,  
21 but what happened was, the plaintiffs' attorneys would say,  
22 Well, no, we actually heard the share is much higher, like  
23 thirty or thirty-five percent.

24 So it became a negotiation, and basically the key  
25 variable in the negotiation became this percent number. So

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1 instead of holding to the ten to twenty percent range, the  
2 Trust started with that number and then got negotiated up to a  
3 higher number inevitably.  
4 Q. If, as you say, the ACF price, the total ACF price was  
5 locked in place, was there any other way that the plaintiff's  
6 lawyer, in trying to do better for his client, could increase  
7 the price other than to negotiate the Manville Share?  
8 A. At this time the Manville Share is what was negotiated  
9 because that was the way that Manville was trying to settle  
10 all these claims, was to focus on share.  
11 Q. Showing you GZ 201049. Is this a document that reflects  
12 some aspect of one of the negotiations in May of 1988  
13 (Handing.)?  
14 A. Yes, it is.  
15 Q. This is May of 1988, during this Pre-C period of time,

16 right?  
17 A. Yes, it is.  
18 Q. And it's on the letterhead of the Manville Personal  
19 Injury Settlement Trust and re Fred Baron visit.  
20 Fred Baron was a very prominent plaintiffs' lawyer?  
21 A. A prominent Texas attorney.  
22 Q. He had a very large number of claims?  
23 A. Very large.  
24 Q. The letter is from to Marianna Smith, the executive  
25 director of the Trust?  
page 5755  
page 5756  
1 A. Yes.  
2 Q. It talks about Gregg being given authority, Gregg Smith's  
3 evaluation, the same Gregg Smith we were talking about a  
4 little earlier?  
5 A. Yes.  
6 Q. It says, I have given Gregg the authority to negotiate  
7 the Texas cases up to 8,120 699 dollars. Gregg will make  
8 every effort to settle the remaining 13 cases for an amount  
9 between 18 and 20 percent.  
10 Is that the reference to that market share?  
11 A. Yes.  
12 Q. In my discussions with Fred, he has indicated that he  
13 would be looking for something between 25 and 30 percent,  
14 which is more than what we want to pay on these cases.  
15 Is this kind of typical, the Trust is aiming for that  
16 ten or twenty but the lawyers are aiming for more?  
17 A. Yes, ten to twenty in the early phases became just a  
18 starting point for the negotiations.  
19 Q. Now, it turned out that ultimately when resolution was  
20 reached with Mr. Baron, this is GZ 201046, is this another  
21 memo from Mr. Smith to Marianna Smith, again talking about  
22 Baron and Budd, Fred Baron?  
23 A. Yes.  
24 Q. Does this reflect that by the time things got to be in  
25 place, that the final cases settled for 13,225 thousand. That  
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1 would be something over 25 percent market share?  
2 A. Yes, because 25 percent market share is about 13.19  
3 million, and they settled it at 13.2 to 3 million.  
4 Q. Is that consistent with the pattern that you saw with  
5 regard to these negotiations?  
6 A. Yes, it is.  
7 Q. Let me ask you something. Did you ever see that the  
8 Trust ever did an actual market share analysis, that is they  
9 sat down and said with respect to any of these negotiations  
10 what really was Manville's portion of the asbestos market so  
11 we can negotiate with these guys, did you ever see that?  
12 A. No.  
13 Q. Did you ever see anything that told the Manville claims  
14 people or the Manville executive directors saying, here's what  
15 our market share is. We should pay no more and we should tell  
16 the plaintiffs' lawyers that's it?  
17 A. No, nothing like that.  
18 Q. Showing you the deposition of Marianna Smith, the  
19 executive director, at page 97 line 4. This again will be  
20 played.  
21 Certainly, if the Trust officers were following -- if  
22 the Trust were following the procedure, the statistical  
23 procedure approved by the Board of Trustees, somebody should  
24 have done a market share analysis and submitted it for

25 approval, that would support picking one of these market  
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1 shares. Correct?

2 Answer: Someone should have, someone may have, I  
3 have no recollection.

4 Question: That would have been a reasonable, and  
5 responsible, and sound procedure, correct?

6 Answer: Yes.

7 Question: I want you to assume for purposes of my  
8 question, Miss Smith, that there is no documentation of such a  
9 market share analysis. Would that have been consistent with  
10 good practice of a Trust in resolving claims?

11 Answer: If one assumes that there was not any form  
12 of statistical analysis, it would not be good practice.

13 Did you ever see such a form of statistical analysis  
14 that they actually used?

15 A. No, not by the Trust.

16 Q. Was another problem that the Trust faced during this  
17 period of time, that is the Pre-C period of time, that there  
18 was not a lot of information that was gathered in order to  
19 analyze the claims?

20 A. That's correct. It was consistent with their  
21 negotiations strategy that they kind of minimized the amount  
22 of information per claim.

23 Q. Showing you GZ 20003. This is already in evidence. Are  
24 you familiar with the memo dated October 22, 1992, from Melvin  
25 Glass to Bob Clair?

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1 A. Yes.

2 Q. This says that it is correct that we settled the  
3 pre-petition cases for less than the court docketed cases that  
4 were set for trial.

5 The pre-petition cases, those are the Pre-C cases?

6 A. That is Pre-C, yes.

7 Q. Were settled in groups because of the expediency factor  
8 and the files were mostly absent of information that would  
9 have allowed them to be evaluated individually. However, this  
10 was what we were told to do and we did it.

11 Did you see any other documentation that the Trust  
12 had made an arrangement with the plaintiffs' lawyers to pay  
13 the Pre-C claims real fast?

14 A. Yes.

15 Q. In fact, is it true that the Pre-C claims, these 15  
16 thousand, 12 to 15 thousand claims, were all negotiated during  
17 a period of time of roughly May of '88 through November of  
18 1988?

19 A. That was the intent. I think about 12 thousand of the 15  
20 thousand were negotiated over that time frame.

21 Q. If we take a look during the period of time of the Post-C  
22 period, again have you analyzed whether the Trust's own  
23 problems and issues affected the negotiation and payment  
24 process?

25 A. Yes.

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1 Q. The jury has already seen GZ 20016, which is a  
2 presentation of the Trust's financial performance in October  
3 of 1988 just before consummation, and they have already seen  
4 that the Trust has got a lot of financial problems -- let me  
5 get the last page -- so much so that they are considering  
6 modification of the plan?



7 A. Yes.  
8 Q. Voluntary compliance on the part of Manville and the  
9 plaintiffs' bar, and even a Trust bankruptcy before it even  
10 opened its doors.  
11 Are you familiar with that documentation?  
12 A. Yes, I am.  
13 Q. Did the Trust realize, even before it actually opened its  
14 doors for business, that it was going to run out of money?  
15 A. Yes, run out of cash.  
16 Q. There has also been testimony that as a result the Trust,  
17 nevertheless, went ahead and decided to open for business and  
18 they went around the country asking lawyers not to file claims  
19 so quickly.  
20 Are you familiar with that?  
21 A. Yes.  
22 Q. What was the consequence of all that, what happened to  
23 the rate of claim filings against the Trust during the Post-C  
24 period of time?  
25 A. The filing rate went up. What happened was the attorneys  
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1 who were being told about the problems of the Trust put 2 and  
2 2 together and came to the realization that the Trust was  
3 going to run out of money.  
4 So that would indeed -- if they filed their claims  
5 late, that would leave their clients kind of high and dry. So  
6 what happened was, in order to get their claims paid first,  
7 they sped up the filing rate, and then they figured out that  
8 if they hadn't gotten a response by the Trust in 120 days,  
9 which was very difficult for the Trust to do because they were  
10 flooded with new claims, they could name the Manville Trust on  
11 an existing lawsuit, just add the name of the Manville Trust  
12 as a defendant on an existing asbestos lawsuit, and that would  
13 force the Trust to come to them to settle, otherwise the Trust  
14 had to go to try their case in court and be -- and risk a  
15 major judgment against it.  
16 Q. As a result of that, what happened to the trial docket,  
17 what happened to the docketed cases that were going to court?  
18 A. They increased. They increased a lot over this time  
19 period. And when you have trials, you have to send attorneys  
20 in to try to defend yourself and that -- and the Trust wasn't  
21 set up as a litigation vehicle.  
22 It was not set up to litigate. It always preferred  
23 settlement, so it didn't have the staffing and it didn't have  
24 the philosophy that that was needed in order to try to combat  
25 these cases at trial.  
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1 To do so would have taken a lot of resources. It  
2 would have cost them much more to try these cases, and that  
3 would have left less money available for the claimants, who  
4 they viewed as their true beneficiaries.  
5 Q. Is it true that a time came away into the Post-C period  
6 of time when the whole process was stopped -- and we don't  
7 want to get into details of how that happened -- just the  
8 process was stopped?  
9 A. Yes.  
10 Q. At that time, is it true that the Trust was spending  
11 almost a million dollars a week on attorney's fees to defend  
12 all those cases?  
13 A. Yes, that's true.  
14 Q. Now, have you taken a look to see whether this flood of  
15 claims and the pressure that it put on the Trust led to the

16 Trust spending more money per claim, that is, it's been  
17 ratcheted up?  
18 A. Yes, I have.  
19 Q. Turning back to GZ 200033, which is the Glass memo, does  
20 this talk again about this period of time?

21 A. Yes, it does.  
22 Q. It says that the court docketed cases were another  
23 matter. They were evaluated individually. However, again,  
24 there were times when we did not have all the information to  
25 be comfortable with the number. But the biggest problem with

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1 these cases was the lack of notice of the trial date.  
2 Many times we received call from defense counsel  
3 advising us that the trial was starting that day. Moreover,  
4 it was the plaintiffs' counsel who informed us that the trial  
5 was imminent. Therefore, because of the courthouse steps and  
6 other related factors the trial docketed cases usually were  
7 settled for a premium amount. Premium amount being what?

8 A. To give you some numbers on this from the standpoint of  
9 planning. When, back in the, say, 1987 time period, when the  
10 Trust was trying to figure out the dollars it had versus what  
11 it was going to pay, about 22 thousand dollars per case was  
12 what they were assuming, and that was based on what the  
13 average had been that Manville itself had settled for before  
14 it had gone into bankruptcy.

15 By this time they were settling the cases for an  
16 average of 47 thousand dollars, which, when you roll that into  
17 the Pre-C cases, meant that over this entire time period, both  
18 the Pre-C and the Post-C, the average was actually 42 thousand  
19 dollars.

20 That was how much they had increased from what they  
21 thought the cases were going to be settled for, from 22 to  
22 42.

23 Q. There's a reference here to the Cimino settlements. Was  
24 that a class action settlement in Texas?

25 A. Yes.

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1 Q. Did Mr. Smith testify about that as well?

2 A. Yes.

3 Q. Showing you page 77 of Mr. Smith's deposition. It says,  
4 Did Marianna Smith settle the Texas class -- she's again the  
5 executive director?

6 A. Yes, she actually -- rather than having the claims  
7 negotiators settle that case, claims negotiators settled most  
8 of the cases, Marianna Smith herself did the negotiation on  
9 the Texas class action, the Cimino case.

10 Q. Mr. Smith testifies as follows on page 78:

11 Do you recall how much more she settled the claims  
12 for than the amount recommended by the people who did the  
13 individual evaluation?

14 Answer: Not exactly. Not much, no.

15 Can you give me an order of magnitude?

16 Answer: Some number of millions of dollars. I would  
17 suggest thirty or forty million. Thirty or forty million, I  
18 don't know.

19 More than the recommended amount?

20 Answer: Forty is probably on the high side.

21 Probably somewhere around 30, I would guess.

22 Are you familiar with her testimony?

23 A. Yes.

24 Q. Did you determine how much the Trust ended up paying

25 during the Pre-C and Post-C period of time as a premium over  
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1 the originally estimated market share of ten to twenty  
2 percent?

3 A. Yes, I did.

4 (Continued next page)

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1 EXAMINATION CONTINUES

2 BY MR. BERNICK:

3 Q. And is this reflected in DEM-012140?

4 A. Yes. Actually the market share that I used was at the  
5 high side of that range, I used twenty percent, so this  
6 says -- this tells us that if they had been able to adhere to  
7 the twenty percent market share, then the amount they would  
8 have paid is shown by the yellow orange wedge and the amount  
9 over that they paid shown by the red wedge.

10 Q. Does this amount have anything to do with anything other  
11 than just the negotiation and claims administration process?

12 A. No. It doesn't have anything else to do with that. It  
13 is just the summation that the Trust found itself in during  
14 this time period.

15 Q. Did this require, these numbers, did they require any  
16 elaborate modeling? Where did you get the information for it?

17 A. These numbers I got off of the claims analysis  
18 summaries. We were able to find the market share numbers off  
19 of those for the post-C periods and then in the preC periods,  
20 we had access to the actual settlement files that the Trust  
21 had for about six thousand of the claimants and in those files  
22 we were able to find out the negotiated share. So I just took  
23 the average share from those files and from the CAS form and  
24 then compared that to what it would be if it was twenty  
25 percent.

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1 Q. Showing you DEM-012141. Let's try then to make a  
2 transition from the pre-TDP period of time. That is, the  
3 transition from here to here.

4 Are you familiar with the fact, Doctor Dunbar, that  
5 the claims that are being made by the Trust in this case focus  
6 on monies that were paid out during the TDP period of time

7 from 1995 to the present time?  
8 A. That's my understanding.  
9 Q. Have you looked to see if impact of all of what we have  
10 discussed about the tobacco discount, have you looked to see  
11 what the impact of that was on pricing during the TDP period  
12 of time?  
13 A. Yes, I did.  
14 Q. Okay. Let's just draw a very similarity to the one we  
15 have here.  
16 THE COURT: When you get a chance, put numbers on  
17 those two charts, please.  
18 MR. BERNICK: Okay. We have a total of one, two,  
19 three, four. This will be number four. Dunbar four.  
20 Q. Would it be fair to say that during the pre-TDP period of  
21 time, the result of all of the monies that had been paid out  
22 for the Manville share during this period of time was to  
23 establish kind of a going price, a historical price for  
24 settling claims?  
25 A. Yes. It's historical averages, historical prices, yes.

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1 Q. Is it also fair to say that in putting together the TDP,  
2 jury has heard testimony about the TDP having scheduled  
3 values. That is, for a given claim, or type of claim, the  
4 price or the dollars that were associated with that.  
5 A. Yes, that's the matrix value.  
6 Q. Okay. Have you looked to see whether in the process of  
7 negotiating the TDP, whether the historical prices were used  
8 to determine the scheduled prices?  
9 A. Yes, I did.  
10 Q. You have told us from your prior testimony that the  
11 historical prices excluded tobacco. It was taken off the  
12 top.  
13 A. Yes.  
14 Q. Did you look to see whether in putting together the  
15 scheduled values that the historical prices were increased in  
16 order to pick up tobacco?  
17 A. I looked at that, yes.  
18 Q. Okay. Did you find historical documented evidence on  
19 whether the historical prices pre-TDP were used to set the  
20 scheduled values? Did you find them?  
21 A. Yes.  
22 Q. The TDP negotiations, did they take place over a period  
23 of time?  
24 A. Yes. They took place from about 1990 through the end of  
25 1994. Or through 1994.

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1 Q. Have you got a series of documents here that span from  
2 1990 up through 1993 and into 1994 that talk about the  
3 negotiation process in setting values?  
4 A. Yes, sir.  
5 Q. During this period of time, is it also fair, that the  
6 proposed TDP also changed itself?  
7 A. Yes, it did.  
8 Q. Okay. Showing you GZ-200365, a memo dated October 25,  
9 1990, from various people, including those claims people, to  
10 Mark Peterson. He was an outside consultant to the Trust?  
11 A. He was an outside consultant, yes.  
12 Q. Okay. Does this relate to comments and suggestions and  
13 value ranges for claims categories?  
14 A. Yes.  
15 Q. Is this one of these documents that's associated with the

16 process of developing the new deal?

17 A. Yes.

18 Q. It says here, number one, our values were derived from  
19 historical averages and, where possible, from the profile  
20 project in beginnings with the historical averages.

21 Is this the kind of documented evidence that you  
22 found regarding the use of historical pricing?

23 A. Yes. This shows the process which the Manville trust was  
24 going through in order to determine WHAT would eventually ---  
25 became the matrix involved the use of the historical averages

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1 of the settlements that they had been paying in the preC and  
2 the post-C time period.

3 Q. The TDP distribution process, this is GZ-201216, was  
4 there an original or earlier TDP proposal?

5 A. Yes, there was, around the 1990, 1991 time frame.

6 Q. Turning to page three. This says, for each type -- claim  
7 valuation -- claim valuation by category. For each type of  
8 disease, the Trust, the selected counsel for the beneficiaries  
9 and the special advisor to the Trust have together established  
10 a midpoint and maximum value for claims against the Trust  
11 based upon experienced settlement values for claims for that  
12 disease.

13 Again, is that a very similar reference in the same  
14 concept?

15 A. Yes.

16 Q. Okay. In fact, the values that were discussed here talk  
17 about anticipated mid-points of one hundred twenty thousand  
18 for the smoker, seventy thousand for the non-smoker. Are  
19 those very similar to what was used in the pre-TDP period of  
20 time?

21 A. In the first TDP, yes. In the latter TDP they were  
22 different.

23 Q. We will talk about how that is true. GZ-201171, is this  
24 another document now in 1993 in connection with the second TDP  
25 to Pat Houser, the executive director, again talking about the

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1 matrix which was going to be the scheduled values?

2 A. Yes.

3 Q. Page two says, there will be a minimum and maximum state  
4 average so that outlier states will be brought within the  
5 normal average range. In fact, by taking the midpoint between  
6 state and national average, all states will be brought closer  
7 to the national average.

8 Again, is this a statement regarding the use of  
9 historical values in developing new values?

10 A. Yes. This is showing that they are converging on the  
11 eventual matrix values by using these averages.

12 Q. When push finally came to shove and the new values were  
13 put together, were those new values in fact, the new values  
14 for the TDP, the scheduled values, were they in fact based  
15 upon the historical values?

16 A. Yes.

17 Q. Were there a couple of adjustments that were made?

18 A. Yes.

19 Q. What were the adjustments that were made?

20 A. The main one was that the pleural claims were reduced in  
21 value. I believe the historical average was on the order of  
22 nineteen thousand, and the matrix value in the final TDP  
23 became twelve thousand. The stated reason for that is that  
24 over this time period, various state jurisdictions began

25 ruling against plaintiffs on pleural claims, claiming that  
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1 because the claimant was really not impaired they couldn't  
2 collect money. So they felt those values declined in value.

3 Also, the mesothelioma -- the top bracket of  
4 mesothelioma matrix value was decreased.

5 Q. There has been discussion about Rabinovitz who  
6 participated in the formulation of the model in this case.  
7 Did she testify in her deposition at page 33, the same way,  
8 that is, question, and that the claims values -- I should say  
9 the scheduled values for the TDP were based upon those  
10 settlement values, and to the extent that they were litigated,  
11 those litigated values?

12 Answer: Yes.

13 Again, is that consistent with exactly the same  
14 point?

15 A. Yes.

16 Q. There has been testimony from the only trustee who has  
17 appeared here, Mr. Macchiarola, testified as follows, at page  
18 1339.

19 Isn't it true that in order to negotiate the TDP  
20 prices to insure that they would be fair, the Trust actually  
21 went back to the -- the claimants themselves went back to take  
22 a look at what the historical values had been, in order to  
23 assure that the new TDP values were consistent with what had  
24 been paid by the Trust in the pre-TDP period? Isn't that  
25 true?

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1 Answer: That's correct.

2 Further on: So basically, the idea was, in coming up  
3 with that schedule of values, that everyone went back to see  
4 what the Trust had paid out, what they had done pre-TDP for  
5 whatever reason, they took the dollars that were set as the  
6 dollars that had been paid out pre-TDP and they set the new  
7 dollars based upon history?

8 Answer: Correct.

9 Again, is that consistent with what you have  
10 discussed?

11 A. Yes.

12 Q. Have you determined whether in fact, in fact, the values,  
13 settlement values pre-TDP line up with the expected values  
14 post-TDP?

15 A. Yes.

16 Q. Have you done that both in the aggregate, that is, with  
17 respect to all money that was paid out pre- and then expected  
18 to be paid post-TDP and have you also done it by certain  
19 diseases?

20 A. Yes.

21 Q. Let's begin with the aggregate. That is, whether the  
22 amount of money that was set to be paid on the TDP was lined  
23 up to be and the schedule was adopted so it would exactly  
24 match the amount of money that had been paid out  
25 historically.

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1 First of all, was there documentation submitted in  
2 connection with the approval process for the TDP which shows  
3 this?

4 A. Yes.

5 Q. Showing you GZ-201214. In going to the liabilities part,  
6 it says, there is a line here saying: Average liquidated

7 value per claim, with class action settlement, that's the new  
8 deal?  
9 A. Yes.  
10 Q. Forty-two thousand eight hundred twenty. Without the  
11 class action settlement, the same number?  
12 A. Yes.  
13 Q. What does that tell us?  
14 A. That number is very close to the average value for the  
15 pre-TDP. The average value pre-TDP was forty-two thousand two  
16 hundred eighty dollars. So this shows that they were keeping  
17 in aggregate the average values close together in the planning  
18 process.  
19 Q. Now, back in a different era of this case, Mr. Austern  
20 was on the stand. He is the former general counsel of the  
21 Trust, now he's running the Trust company, whatever it is. We  
22 had a long discussion back and forth about how much money was  
23 actually paid out on average pre-TDP and the average  
24 liquidated value under the TDP. We went back and forth on  
25 whether it was the tort system or historical values.

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1 Ultimately we filled out what is Austern number two and it  
2 shows under the pre-TDP period of time, average value,  
3 forty-two thousand. Under the actual TDP, average liquidated  
4 value, forty-two thousand.  
5 Do these numbers all line up?  
6 A. Yes.  
7 Q. What do they tell us about whether the before picture and  
8 after picture, that is, the pre-TDP and post-TDP, were  
9 designed to line up and be the same?  
10 A. This shows that the -- they had planned the TDP to have  
11 the same overall average value as had been their historical  
12 experience.  
13 Q. This was his testimony, at page 2124.  
14 Question: Is it correct to say that the average cost  
15 of resolution pre-TDP is on average the same as the average  
16 scheduled value under the TDP?  
17 Answer: Yes, it is the same scheduled -- the average  
18 of the scheduled values is the same.  
19 If that is true, what does that tell us about whether  
20 the scheduled values were increased in order to start to pay  
21 for tobacco? What does that tell us?  
22 A. That they were not. The historical values excluded  
23 shared causation, which was the tobacco portion of the  
24 damages, and the fact that the TDP values are about the same  
25 as the pre-TDP values, means the tobacco was also excluded.

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1 Q. I asked him that very same question. Page 2206, line 17  
2 in this trial.  
3 Question: Isn't it a fact, Mr. Austern, that under  
4 the TDP there was no change in the net aggregate amount that  
5 the Trust was paying?  
6 Answer: There was no change in the net aggregate  
7 amount.  
8 Is that consistent or inconsistent with what you  
9 found?  
10 A. That's consistent.  
11 Q. Does DEM-012142 reflect the actual numbers?  
12 A. Yes.  
13 Q. What does that say about the Manville share that was  
14 actually paid by the Trust pre-TDP and the Manville share that  
15 was scheduled for payment by the Trust post-TDP?

16 A. They were virtually the same.  
17 Q. Did you do the same analysis by disease category for lung  
18 cancer, and asbestosis and BID?  
19 A. Yes.  
20 Q. Okay. How did you go about doing that?  
21 A. What we did was we computed that the average lung cancer  
22 claim had been pre-TDP, both the smokers and non-smokers, and  
23 then we computed what the anticipated average would be with  
24 the TDP at the time that it was being negotiated, taking into  
25 account how the claimants would likely distribute themselves

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1 among category six, category five and some lung cancer  
2 claimants would actually end up in category zero with no  
3 payment at all.  
4 Q. Okay. What did you determine? Was this a little bit  
5 more complicated an analysis?  
6 A. Somewhat.  
7 Q. Okay. Do we have DEM-012143? Does this show how the  
8 overall averages preTDP and projected TDP actually would line  
9 up for lung cancer?  
10 A. Yes, it does.  
11 Q. Now, we know that pre-TDP smokers were paid on average  
12 less than non-smokers.  
13 A. Correct.  
14 Q. Was the same approach, there has been a lot of testimony  
15 about the pricing of these categories under the TDP. Was the  
16 same approach taken under the TDP or not?  
17 A. The same approach was taken.  
18 Q. Okay. When it came to actually pricing, was it necessary  
19 for the difference between category one and category two under  
20 the TDP, is that designed to somehow capture the whole  
21 difference between smokers and non-smokers so it's to avoid  
22 paying for the tobacco share or is it something that is  
23 different?  
24 A. It is different.  
25 Q. Tell the jury how it is different.

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1 A. Category -- instead -- remember earlier in the first TDP  
2 what they had said was that a category one was going to be one  
3 hundred twenty thousand and a category two was going to be  
4 seventy thousand. In the course of the negotiation, the one  
5 hundred twenty thousand actually became ninety thousand.  
6 The reason for that was that they let into category  
7 one, in addition to the non-smokers who had lung cancer, a  
8 group of people who would have smoked but would have had other  
9 additional evidence of an asbestos related disease and so  
10 those folks are ones who -- though they nonetheless smoked,  
11 you could say with some confidence that at least a large part  
12 of their disease was due to the asbestos exposure.  
13 Letting those -- that fraction of non-smokers into  
14 the top category along with -- I'm sorry. Letting that  
15 fraction of smokers into that category along with the  
16 non-smokers caused that one hundred twenty thousand to drop to  
17 ninety thousand because we were letting a lot more people in.  
18 The category two then became reserved for all the  
19 rest of the people who had fifteen years or more of exposure.  
20 So that would be only smokers with fifteen years or more of  
21 exposure and then the rest of the lung cancers dropped out.  
22 They became zeros. Those would always be smokers also.  
23 Q. Were category one and category two prices on the TDP  
24 designed to actually raise scheduled values beyond what they



25 had been and pick up tobacco? Were they designed to do that?

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1 A. No.

2 Q. Did the Manville share, that is, the portion that  
3 Manville was said to be Manville's, did that remain the same  
4 or was it different as you went to the TDP?

5 A. In terms of the scheduled values, it was the same.

6 Q. When it came to shared causation, the tobacco portion,  
7 even under the TDP, was that claim excluded from the amounts  
8 that were scheduled for the Trust to pay?

9 A. Yes, on average.

10 Q. Now, there is one big difference, isn't there, between  
11 the prices that were pre-TDP and the payout, the payout  
12 pre-TDP and payouts under TDP?

13 A. Yes.

14 Q. What is that difference?

15 A. They are paying out ten percent.

16 Q. They are paying out ten percent.

17 Let's do the same chart here. Modified. DEM-012148.

18 Does this graphically illustrate to the jury, I  
19 really wish we could do better on the graphics.

20 Does this illustrate to the jury the ten percent  
21 point?

22 A. Yes.

23 Q. The ten percent we have the same Manville share?

24 A. Twenty-seven percent over all.

25 Q. Twenty-seven percent. Is this the scheduled value under

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1 the TDP?

2 A. Yes.

3 Q. Does it correspond to that right bar over there?

4 A. Yes, it does.

5 Q. The amount that actually is paid by Manville is ten  
6 percent?

7 A. Yes.

8 Q. Which would mean that the percent of Manville -- the  
9 percent of the total value, the percent of the total value  
10 actually paid by Manville is what percent?

11 A. Three percent, rounded.

12 Q. Does this remain true for not only lung cancer but also  
13 BID and DBID?

14 A. Yes.

15 Q. Now, the ten percent is only a portion of the Manville  
16 share, is that what you said?

17 A. Yes.

18 Q. Okay. I want to read or show to the jury -- actually,  
19 there are two that I had here.

20 A request for admission. This is request for  
21 admission number 86. It is GZ-201246.

22 It says: Request, admit with respect to all claims  
23 resolved pursuant to the TDP the Trust has not yet paid out  
24 all of Manville's liability.

25 The response is this: Admitted that with respect to

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1 claims resolved pursuant to the TDP, the Trust's ten percent  
2 payments to each claimant does not exhaust Manville's  
3 liability as assumed by the Trust to each or any claimant.

4 Is that consistent or inconsistent with your own  
5 understanding?

6 A. That would be consistent.

(Continued on next page.)

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1 Q. Showing you the testimony of Mr. Macchiarola, who  
2 testified as the Trustee, at page 1357, line 14.

3 Isn't it a fact that Manville's  
4 liability -- Manville's share, forget about  
5 tobacco -- Manville's share, Manville's liability, what the  
6 Trust is supposed to be paying, far exceeds the 10 percent  
7 dollars that are being paid out today and have been paid out  
8 in the past, true or not?

9 Answer: That's true.

10 Again, is that consistent with your own views as you  
11 formed them here?

12 A. Yes.

13 Q. That amount that's paid, does that include any tobacco  
14 shared causation dollars?

15 A. No.

16 Q. Where are the tobacco share causation dollars, as defined  
17 by the Trust's own procedures?

18 A. That's the part that's not paid. The shared causation is  
19 taken out of the gross value and is not paid by Manville.

20 Q. The amount that's actually paid, is that Manville  
21 liability, is it tobacco liability, is it Manville Share,  
22 tobacco share, or somebody else's share?

23 A. The amount paid is supposed to be Manville only  
24 liability, both with respect to asbestos and noted causes of  
25 the diseases.

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1 Q. Now, even though -- is that your opinion based upon all  
2 that you have reviewed, the documents, the prices, the  
3 analysis, the history?

4 A. Yes, it is.

5 Q. Let talk about what the Trust is claiming in this case.  
6 The Trust is saying that of the amount that its actually paid,  
7 a part is due to us and recoverable from us. Have you  
8 indicated that here on your chart?

9 A. Yes.

10 Q. That is of the amount they have paid out, we're  
11 responsible for a slice. Is that inconsistent or consistent  
12 with how the Trust's prices and values have been determined  
13 and paid?

14 A. I find that inconsistent because the Trust hasn't  
15 actually paid out for tobacco dollars.

16 Q. As the Trust is making its claim here, given that claim,  
17 whose money, whose liability, whose share is the Trust saying  
18 that we should pay?

19 A. Any amount that comes out of the Manville Share, as they  
20 have already settled it, would be Manville's liability.

21 Q. I want to show you DEM 012152 to kind of maybe do a  
22 little bit of a recap here on the history and how it works  
23 out.

24 I know we have gone through pies and other things,  
25 and I have a large version of it here.

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1 During the ACF period of time -- you may want to  
2 stand down here a for a second, Dr. Dunbar, so you can point  
3 this out and do the talking instead of me.

4 During the ACF period of time, before the Trust, who  
5 was it that was paying the claims, was it Manville or was it  
6 the other asbestos companies?

7 A. These are the thirty to forty asbestos companies that  
8 were in the asbestos claims facility.

9 Q. Now, when the ACF agreed to pay claims, did they or did  
10 they not exclude tobacco?

11 A. They excluded tobacco.

12 Q. Did they or did they not exclude Manville's share of the  
13 asbestos liability?

14 A. They excluded all the non-ACF codefendants, and that  
15 included Manville. Manville was not part of the ACF.

16 Q. Now, you told us that the ACF prices were carried over to  
17 the Pre-C settlement. Would that be roughly like here?

18 A. Yes.

19 Q. And that as a consequence, the tobacco portion, again,  
20 was excluded from the Pre-C settlements; would that be fair?

21 A. Yes.

22 Q. What about the liability of the other asbestos companies,  
23 did Manville have to pay the liability of the other asbestos  
24 companies?

25 A. No. That was not part of their charge. They tried not

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1 to pay that.

2 Q. So the idea was, in the Pre-C period of time, is that  
3 nobody pays for tobacco, and now the other piece of the  
4 asbestos liability gets paid, is that correct?

5 A. Yes.

6 Q. Let's go to the Post-C period of time. This is now  
7 individual evaluation, the form that you showed us?

8 A. Yes.

9 Q. Again, was or was not tobacco excluded from the Manville  
10 payment?

11 A. Manville consciously excluded tobacco in the shares  
12 causation, that's correct.

13 Q. What about the liability of other asbestos manufacturers,  
14 was that included or excluded from the Manville payments?

15 A. That was excluded in the Manville Share.

16 Q. Now, in going from Post-C to TDP, I think you told us on  
17 that chart right there that the values, by design, were to  
18 remain the same. Those are the scheduled values?

19 A. On average.

20 Q. Again, does that mean that tobacco is included or  
21 excluded from the payment under the TDP?

22 A. Tobacco is excluded from the average in the TDP.

23 Q. And actually I probably drew the wrong line. It should  
24 have been scheduled values down here. Is that correct?

25 A. Yes.

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1 Q. They exclude both tobacco and other asbestos?

2 A. Yes.

3 Q. But the amount that Manville is now paying has been  
4 reduced ten percent?

5 A. Correct.

6 Q. Is that a fair representation of the sequence that we  
7 followed here?

8 A. Very fair.

9 Q. Thank you. I will put this one in place and ask you one  
10 more line of examination and I'm done.

11 For the record, I'm not sure I said it, DEM 011252.

12 Did you also take a look in the same fashion -- you  
13 told us during the Pre and Post-C period of time that  
14 Manville, the Trust, ended up paying a premium amount by  
15 reason of some problems that the Trust had. Do you recall  
16 that?

17 A. Yes.

18 Q. Do we have a similar problem with respect to the amounts  
19 that were paid by the Trust during the TDP?

20 A. Well, you have the scheduled amounts, because they were  
21 based on these historical averages. Then the scheduled  
22 amounts also include those -- the scheduled amounts also  
23 include that meaning.

24 Q. Were there other problems that the Trust had during the  
25 TDP period of time?

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1 A. Yes, there were.

2 Q. What were those problems with?

3 A. What happened was, in the negotiations, in order to  
4 reduce the cost to the Trust of administering the claims and  
5 getting out of the tort system, they created a procedure where  
6 data would be sent to the Trust from, again, the plaintiffs'  
7 attorneys, and the Trust would look at it and classify that  
8 claimant as either having enough data and falling into a  
9 particular point on the matrix, or not, and what happened was  
10 the criteria that were used allowed a lot of claims to come in  
11 from people who were unimpaired or didn't have actually the  
12 proper support for the diseases that they were getting paid  
13 for.

14 So the amount of claims went way up, much  
15 higher -- to a much higher number than they had anticipated.

16 Q. Did the Trust conduct an audit in order to find out what  
17 the cause of the problem was?

18 A. Yes, they did.

19 Q. What did they find as a result of the audit?

20 A. They found that there were probably overpayments in just  
21 about every category, but they found that the BID category was  
22 the one which had the worst problem.

23 In the course of an audit, which was arguably very  
24 pro-plaintiff, they ended up finding that in many time periods  
25 that over fifty percent of the claims failed the audit.

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1 Q. Is there extensive documentation of this, that we're not  
2 going to go through again today?

3 A. Yes.

4 Q. Did even Patricia Houser, the executive director of the  
5 Trust, come to the conclusion, in her own review of the  
6 situation, that the TDP was not being followed and the claims

7 that were being filed were not entitled to compensation, did  
8 she come to that conclusion?

9 A. Yes.

10 Q. Is the same kind of conclusion expressed in the  
11 correspondence, including correspondence even from Mr.  
12 Austern, who testified here?

13 A. Yes, that's correct.

14 Q. Was the position of the Trust in all of that  
15 correspondence and all those negotiations for years and years  
16 that basically what was happening was that the criteria for  
17 these diseases were not actually being followed and that  
18 people were filing claims that really were not proper  
19 claims?

20 A. Initially, the criteria were not being followed. They  
21 tightened up on the criteria. They still had major problems  
22 in that the criteria were not being followed, and they were  
23 getting a lot of claims where there just wasn't the support  
24 for the disease and they had to pay the claims anyway, as per  
25 the negotiated settlement of the TDP.

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1 Q. Showing you Mr. Macchiarola's own testimony here in this  
2 court, page 1345. I asked him:

3 You can't tell us whether any or what portion of the  
4 TDP claims that were paid were for people that actually had  
5 lung cancer, can you?

6 Answer: That's correct.

7 Question: You can't tell us what portion actually  
8 had asbestosis, correct?

9 Answer: I believe that is correct.

10 Question: You can't tell us which ones actually had  
11 bilateral interstitial disease, correct?

12 Answer: That is correct.

13 Page 1346.

14 You cannot tell us which ones of the claimants, or  
15 what group of the claimants, in fact, even satisfied the TDP's  
16 lesser standards, can you?

17 Answer: Same answer.

18 Again, is that consistent with what you have read in  
19 these documents?

20 A. Yes.

21 Q. Have you done your own review of some of the underlying  
22 facts?

23 A. Yes.

24 Q. Have you done your own analysis of the quantitative  
25 impact of those facts?

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1 A. Yes.

2 Q. Showing you DEM 012153. Does this reflect the results of  
3 the audit with respect to some of the highest volume doctors?

4 A. Yes. These were doctors that were preferred doctors by  
5 some of the largest plaintiffs' law firms, and these doctors  
6 would be submitting hundreds of analyses for x-rays and  
7 analyses of x-rays in the claim files, and when the Trust had  
8 two people reread the x-rays, if one of those agreed with one  
9 of these doctors it passed the audit, but if both of them  
10 disagreed with these doctors then it failed the audit, and  
11 this shows the result for some of these high volume doctors.

12 Q. Did you prepare your own chart about the financial impact  
13 of this problem?

14 A. Yes.

15 Q. Showing you DEM 012154. Again I apologize for the

16 quality. We were going to get the TV back in here this  
17 morning but we didn't have time to set it up.

18 Does this reflect the results of your analysis of  
19 some of the numbers?

20 A. Yes. This shows the actual payments for asbestosis made  
21 in the TDP, and what I did was I deducted out over this time  
22 period the percentage of the claims made by these doctors that  
23 failed the audit, just those ten doctors.

24 I didn't even look at other doctors that failed the  
25 audit. You see it's about a hundred million dollar issue.

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1 Q. Does this difference have anything to do with tobacco?

2 A. No.

3 Q. Did the extra amounts that were paid by the Trust as a  
4 result of its own problems during the Pre-C and Post-C periods  
5 of time, did they have anything to do with tobacco?

6 A. No, they did not.

7 Q. Did some of the problems that the Trust had even affect  
8 the projected mix of claims between these different  
9 categories?

10 A. Yes. That's correct.

11 Q. Let me be clear. When you developed this number, there  
12 was a projected mix of claims, right?

13 A. Right. For those that were not marked down to category  
14 0, the projection initially was going to be two-thirds in the  
15 first category, category 1, and then one-third in category 2.

16 So that was 67 percent versus 33 percent. That was  
17 marked up a little bit by 1994. But basically that's the  
18 range that we're talking about.

19 Q. And as it actually evolved because of some of the  
20 problems that the Trust had with its claims process, did it  
21 affect that mix?

22 A. That mix is 85 percent in category 1 and 15 percent in  
23 category 2.

24 Q. Setting aside the problems that the Trust actually had  
25 with the criteria that it created, that is this problem with

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1 the TDP criteria and this leakage that you've referred to, in  
2 your own experience, you have worked with a lot of different  
3 claims facilities, have you not?

4 A. Yes.

5 Q. The procedures that the Trust adopted in order to avoid  
6 paying for any share, the Manville Share that is, the  
7 procedures that it adopted Pre-C, Post-C and TDP to make  
8 paying values and payments that didn't require that the Trust  
9 pay for other asbestos, and it didn't require that the Trust  
10 pay for tobacco, were those good procedures, that is, was the  
11 Trust diligent in avoiding paying for tobacco?

12 A. I think the Trust did try to avoid paying for tobacco in  
13 the Pre-C and the Post-C period. They used the ACF deduction  
14 in the Pre-C, they put in their own deduction in the Post-C,  
15 and then that carried through to the matrix values in the  
16 TDP.

17 Q. Even when it came to determining how to carry forward the  
18 aggregate values, did the Trust do a pretty decent job in  
19 figuring out how to carry forward the aggregate values,  
20 indeed, the category values?

21 A. Yes.

22 Q. I want to get back to the question that I have back here  
23 about, we know that from your testimony, before the TDP --  
24 it's over here too -- I can point either way -- there was this

25 effort to avoid paying for tobacco.

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1 Are you aware, we've asked witnesses on the stand  
2 whether at any point in time prior to this lawsuit being  
3 filed, did anybody at the Trust or outside the Trust take the  
4 position that the Trust was paying for tobacco now?

5 We've asked everybody that question and I'll  
6 represent to you that nobody has said, yes, before the lawsuit  
7 was filed, we said we were paying for tobacco.

8 Have you seen any evidence whatsoever that in the  
9 development of the TDP, in the effectuation of the TDP, that  
10 there was somehow an effort to increase those scheduled values  
11 so that the Trust would start to pay for tobacco liability,  
12 have you ever seen anything like that?

13 A. I have not seen anything like that.

14 MR. BERNICK: That's all I have, your Honor.

15 THE COURT: Do you want a few minutes before you  
16 start in?

17 MR. STENGEL: A couple of minutes would be helpful,  
18 your Honor.

19 THE COURT: Take a break, please.

20 (Jury leaves the courtroom.)

21 MR. BERNICK: I have a question for the court, if  
22 you have a moment?

23 THE COURT: Yes. You may step down.

24 (Witness leaves the stand.)

25 MR. BERNICK: Your Honor, you will notice that I did

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1 not make use of the dollar figure of the Trust's claim. I had  
2 a graphic prepared to indicate where the Trust's dollar claim  
3 fit into the picture and I couldn't do it because I still  
4 don't have that dollar figure.

5 I'm not quite sure what to do, except that I suppose  
6 it will mean that we're not really -- I'm going to have to  
7 reserve to call Mr. Dunbar back. I really don't want to do  
8 that.

9 THE COURT: No. You can have him do it outside the  
10 presence of the jury and we will put it in later.

11 MR. BERNICK: All right.

12 (Recess.)

13 (Jury present.)

14 THE COURT: Yes.

15 CROSS-EXAMINATION

16 BY MR. STENGEL:

17 Q. Good afternoon, Dr. Dunbar. How are you?

18 Dr. Dunbar, I'm going to -- I think timing is  
19 important here -- I am going to create a different time-line  
20 which I will put on this board, and we will call this  
21 Plaintiffs' Dunbar 1.

22 I don't claim any great artistic ability, but we'll  
23 see what we can do.

24 The Trust history starts basically in 1988, correct?

25 A. Well, the Trust was staffed in '87, but if you want to

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1 start in '88, fine.

2 Q. Let's put 2000 over there, and you talked basically about  
3 three time periods this morning, correct, Pre-C -- what dates  
4 did you attach to the Pre-C period?

5 A. Pre-C period, in terms of negotiations are --

6 JUROR: Excuse me. We can't hear you.

7 Q. I'd ask you to speak up, sir.  
8 Dr. Dunbar, you probably can't see it?  
9 A. It's all right.  
10 MR. STENGEL: Everybody on the jury see that?  
11 Q. Dr. Dunbar, can you see the board?  
12 A. I can, thank you.  
13 Q. All right. I would ask you what dates you attached to  
14 the Pre-C period?  
15 A. Pre-C period is basically 1988. Negotiations occurred,  
16 most of the negotiations occurred between May and November of  
17 1988.  
18 Q. So this, in your world view, is the Pre-C period?  
19 A. Yes.  
20 Q. How about Post-C?  
21 A. Post-C goes up to about middle of '91, around that  
22 point --  
23 Q. Middle of 1990, perhaps?  
24 A. 1990, yes.  
25 Q. Then you have a period of years where there were

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1 negotiations of what eventually became the TDP, correct?  
2 A. Yes.  
3 Q. The TDP was actually implemented in 1995?  
4 A. Early '95, yes.  
5 Q. Now, in the period 1990 to 1995, it's not like nothing  
6 was happening, though, correct?  
7 Although no claims were being paid, there were  
8 extensive negotiations over the TDP, correct?  
9 A. Yes.  
10 Q. And there were at least two very different versions of  
11 the TDP, correct?  
12 A. There were two different versions, yes.  
13 Q. The first one was negotiated sometime in '90, '91?  
14 A. Yes.  
15 Q. That's the first TDP period. The second one basically  
16 occupies the remainder of the period to '95?  
17 A. Well, since -- basically it starts in '95, but it was  
18 negotiated, again, say, in the '93 time period.  
19 Q. So we have negotiation for the second TDP.  
20 Then from 1995 on, we have had the payments that are  
21 at issue in this case, right?  
22 A. Correct.  
23 Q. Now, in the rest of the asbestos world, things were  
24 happening, correct?  
25 A. Yes.

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1 Q. All along this period, you had active litigation  
2 involving other manufacturers?  
3 A. More or less, yes.  
4 Q. And you had a sequence of asbestos manufacturers going  
5 into bankruptcy, just like Manville had?  
6 A. Yes.  
7 Q. And we'll call that the court system?  
8 A. Yes.  
9 Q. As far as it relates to this.  
10 And you also obviously had changes in price levels  
11 during this time, correct, this 12-year period?  
12 A. That's not necessarily true. I can explain, if you  
13 want. If you're talking about average prices aggregated by  
14 particular disease, that's not necessarily happening.  
15 Q. I'm sorry, your sophistication is beyond mine. I was



16 just asking on a simple basis whether the consumer price index  
17 had gone up over that 12-year period.

18 A. The CPI has, yes.

19 Q. So you've got some amount of inflation going on at the  
20 same time.

21 Now, you talked about these various periods in fairly  
22 summary form this morning on direct, and because I want the  
23 jury to understand exactly how you did some of these  
24 calculations, we will revisit these in some greater detail.

25 My next question is, I think you gave us this number

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1 earlier, but how many claims were settled in the Pre-C  
2 period?

3 A. It depends on when you're talking about. But if you said  
4 15 thousand or thereabouts, you'd be pretty close.

5 Q. Fifteen thousand here, and how many Post-C?

6 A. Another twelve, say.

7 Q. Okay. You know that in terms of the TDP, it's a 300  
8 thousand plus number?

9 A. Yes.

10 Q. And I don't represent that that's proportional, but  
11 obviously a lot more has happened by way of settlement since  
12 the TDP was put in place, correct?

13 A. If by a lot more you mean claims volume, yes, that's  
14 correct.

15 Q. A lot more claims had been settled.

16 Now, the next thing I want to point the jury to, and  
17 we'll use these numbers as we go through the day, is you  
18 talked about two calculations, you talked about -- actually  
19 three, I correct myself -- you talked about the market share  
20 premium?

21 A. Yes.

22 Q. And to calculate that, you used a group of Pre-C claims,  
23 correct?

24 A. Both Pre-C and Post-C.

25 Q. How many claims did you use to do the calculation?

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1 A. Well, Pre-C, I think there are six thousand claims in the  
2 database, and we had information on about 3000 other. Post-C,  
3 several hundred.

4 Q. So we've got 3000 Pre-C claims that you base your  
5 analysis on -- and I will refresh your recollection, I think  
6 on the Post-C its 591, correct?

7 A. That sounds about right.

8 Q. And the 591 are the ones you used to do the initial  
9 calculation of your smoking discount, correct?

10 A. Yes.

11 Q. So we have some relationships laid out, just so there is  
12 no confusion, in the Pre-C period, you saw some documents that  
13 talked about not having a lot of information for Pre-C  
14 settlements?

15 A. That's correct.

16 Q. Now, as a matter of fact, I think you even testified to  
17 this, Mr. Smith and other claims officers at the Trust had  
18 worked at the ACF prior to coming to the Manville Trust,  
19 correct?

20 A. That's correct.

21 Q. And as a matter of fact, they had settled a substantial  
22 number of these very same claims for the ACF, hadn't they?

23 A. I'm not sure that's correct.

24 Q. The ACF had already settled a large number of the Pre-C

25 claims?

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1 A. The ACF has settled a large number of the Pre-C claims.  
2 What I might dispute is whether Mr. Smith himself had settled  
3 a large number of the Manville claims.

4 Q. All right. And you've told us that Pre-C was  
5 characterized by group settlements where a law firm would sit  
6 down with someone from the Trust and negotiate a deal?

7 A. Yes.

8 Q. But they were negotiated, right, they would sit down,  
9 they would have a list of cases, they would talk about the  
10 cases, go to each case and the money to the group?

11 MR. BERNICK: Objection to the form of the  
12 question. It's really a compound question.

13 THE COURT: If you know. If you don't know, say so.

14 A. They were negotiated that way, yes.

15 Q. There was somebody on each side of the table trying to do  
16 the best they could for their client or, in the case of  
17 Manville, the Trust?

18 A. That's a more difficult question to answer. I would  
19 definitely say the plaintiff's attorney is trying to do the  
20 best the plaintiff attorney can for the plaintiff's attorneys  
21 clients.

22 The Manville Trust people, it's not clear who the  
23 Manville Trust thinks is their client, whether it's the future  
24 claimants, the current claimants. What it is, is not quite  
25 clear. I kind of disagree with that.

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1 Q. So you think they were burdened by their fiduciary  
2 obligations?

3 A. The Trust was set up with a set of objectives, and it had  
4 a view as to what the beneficiaries were that did -- that in  
5 fact did burden them, and that other Trusts since then have  
6 been able to resolve in a better way for the future  
7 claimants.

8 Q. Let's turn to the Post-C period. This was, as you told  
9 the jury this morning, an era of individual negotiations?

10 A. Yes.

11 Q. So each case was negotiated between the Trust and the  
12 claimant or the claimant's attorney?

13 A. Yes, it was.

14 Q. And then we get to 1990, and payments in claim processing  
15 stopped?

16 A. Yes.

17 Q. And there are discussions around the first TDP,  
18 negotiations?

19 A. That's right.

20 Q. And the participants in that negotiation are lawyers for  
21 the Trust?

22 A. Yes.

23 Q. And lawyers for co-defendant manufacturers and  
24 distributors?

25 A. Yes.

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1 Q. And a futures representative?

2 A. Yes.

3 Q. And lots and lots of different plaintiffs' lawyers?

4 A. Well, there is something called the SEB, which had three  
5 or four or five plaintiffs' attorneys; there was a  
6 representative for that group, and then at various negotiating

7 sessions other attorneys on an ad hoc basis would come in and  
8 out, that were plaintiffs' attorneys.  
9 Q. I don't think we need to bother the jury with the  
10 details, but the first TDP with its level 1 and level 2,  
11 you're familiar with all that, aren't you?  
12 A. I remember much of it.  
13 Q. It was a fairly complex structure?  
14 A. Yes.  
15 Q. And it was a very different structure than the Post-C or,  
16 indeed, the Pre-C periods had been in terms of how the  
17 settlement process was structured?  
18 A. That's correct.  
19 Q. But for reasons we won't go into here, the first TDP was  
20 unsuccessful, correct?  
21 A. That puts kind of a spin on it.  
22 Q. It was never implemented?  
23 A. It was never implemented, I think is more correct.  
24 Q. Is that fair?  
25 A. Yes.

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1 Q. Then we have a second TDP?  
2 A. Yes.  
3 Q. That second TDP was, again, the product of negotiations  
4 among all these interested groups?  
5 A. Yes.  
6 Q. And this was different again because the second TDP  
7 introduced the matrix concept?  
8 A. Yes.  
9 Q. And that was a very different way, because none of these,  
10 either the Pre-C, the Post-C or the first TDP, had had a  
11 schedule of values where you could process a large number of  
12 claims just by picking a category?  
13 A. That's correct.  
14 Q. So that was a substantial change over the prior payment  
15 plans, correct?  
16 A. That's right.  
17 Q. And as a matter of fact, that substantial change is  
18 probably the only reason that the Trust has been able to  
19 process and pay more than 300 thousand claims since 1995?  
20 A. Well, there's cause and effect. You know, that change  
21 also caused 300 thousand claims, also. And then they  
22 processed the 300 thousand.  
23 Q. That's a difference of opinion we'll explore. But you  
24 would acknowledge, without the matrix and without the changes  
25 made in the TDP, these results couldn't have been achieved,

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1 just in terms of sheer processing volume?  
2 A. They would have had -- it would have been very  
3 expensive. They would have really had to have staffed up a  
4 lot in order to do that on an individual evaluation on the  
5 Post-C procedures.  
6 Q. And you personally were working with various asbestos  
7 manufacturers in the tort system over this period of time,  
8 correct?  
9 A. Yes.  
10 Q. And you were working for the NGC in the early nineties?  
11 A. NGC?  
12 Q. Yes.  
13 A. Yes.  
14 Q. And you were sort of paying attention to this process.  
15 Let's turn now more specifically your market share analysis,

16 and I will put this down.  
17 Your market share calculation -- let me make sure  
18 we're very clear on one point. You have a market share driven  
19 premium in your view of the world, correct?

20 A. Yes.

21 Q. Then you have a tobacco discount in your view of the  
22 world?

23 A. Yes.

24 Q. Then you have, one of the last things you talked about  
25 with Mr. Bernick, a claim of a premium or inefficiency in the

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1 TDP, your sort of medical audit driven inefficiency?

2 A. More volume than inefficiency criteria.

3 Q. You used something different to calculate each one of  
4 those numbers?

5 A. That's correct.

6 Q. We didn't put it on here --

7 A. Well, actually I should take that back. In terms of the  
8 Manville Share there is some overlap of the data that I used  
9 and the smoking discount, the same database.

10 Q. I think I understand that. But so what you're saying is  
11 when you do the share, you're using not only the Pre-C claims,  
12 but using that 591 that you're also using to do the smoking  
13 discount?

14 A. The average smoking discount, yes.

15 Q. So that's what you mean when you use the same data?

16 A. Yes.

17 Q. Now, counsel showed you a document -- strike that.

18 Your market share premium is literally just that, you  
19 talked to the jury this morning about docket pressures?

20 A. Yes.

21 Q. But you don't separately try and quantify docket  
22 pressure, you used the market share as a proxy or an  
23 explanation for how you might value the docket?

24 A. Well, by the time that you get to the Post-C there's also  
25 that history of higher market shares that have been driven by

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1 the pressure put on the Trust to settle all the claims, all of  
2 the Pre-C claims in a very short period of time.

3 So you have a combination of two factors by the time  
4 you get to the Post-C, both the docket pressure and at that  
5 point the prior history.

6 Q. But my question was really simpler, I think. It's just  
7 that when you try and calculate for this jury what the premium  
8 is based on market share, you're not doing some separate  
9 formula or statistical analysis to look at docket pressure or  
10 anything else you find objectionable about the way the Trust  
11 process its base claims?

12 A. Well, I didn't use the term objectionable, in the first  
13 place. But what I do is, I use 20 percent as a benchmark of  
14 what they would have paid out had they held the market share  
15 to the historic value.

16 Q. And your premium is all derived from whatever you think  
17 the gap is between what they actually achieved and 20 percent?

18 A. It's what the data showed the gap is between 20 percent  
19 and what they paid out.

20 Q. But you have to presume that 20 percent is appropriate,  
21 correct?

22 A. Yes.

23 Q. If the 20 percent should have really been 30 percent,  
24 that substantially reduces the premium you find, correct?

25 A. That's correct.

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1 Q. And if your calculation of the share is overstated, there  
2 may not be any basis to find a premium anywhere here, right?

3 MR. BERNICK: I object to the form of the question,  
4 the calculation of the share.

5 THE COURT: If you can't answer it say so.

6 A. I just missed the question. Sorry.

7 Q. That's all right. I didn't mean to suggest that you  
8 calculated the 20 percent. I did suggest that -- and I  
9 believe you testified you calculated the other end of this  
10 equation, and all I'm trying to establish is if we close that  
11 gap, the jury doesn't believe you in terms of what the  
12 differential is, you don't have a basis to come in here and  
13 say that there's a premium, apart from what you do in the  
14 medical audit in the TDP period?

15 A. Right, if the jury believes that it should have been 30  
16 percent, and if the jury believes that it actually was 30  
17 percent, that would reduce the premium to zero.

18 Q. Okay. Let's look at the only document you showed the  
19 jury in terms of supporting the 20 percent. This is, for the  
20 record, GZ 200051.

21 It's a document called Pre-C Settlement Strategy,  
22 which is a draft report prepared March 30, 1988.

23 Now, I believe counsel showed you this text, which  
24 says the ten to twenty percent range -- see that, Dr. Dunbar?

25 A. Yes.

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1 Q. This is where you, in the first instance, identify the 20  
2 percent, correct?

3 A. Can I read that a for a second?

4 Q. Do you need it enlarged?

5 A. Yes. I'm at an age where I can't see with either glasses  
6 or not.

7 Q. This is a document you and Mr. Bernick discussed this  
8 morning.

9 A. Yes.

10 Q. All right. I'd like to call the jury's attention to some  
11 aspects of the document that you didn't share.

12 First, Dr. Dunbar, this is shown as a draft report.  
13 Have you ever seen a final?

14 A. Yes.

15 Q. And it's Pre-C settlement strategy?

16 A. Yes.

17 Q. And the first line describes the memoranda as a strategic  
18 plan?

19 A. Yes.

20 Q. And if we turn to the next page of the document, it  
21 reads, the Manville Share results from a consideration of  
22 historical values, market share and ability to pay.

23 So they are introducing the concept of ability to pay  
24 there.

25 This process will yield an acceptable range of values

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1 wherein the Trust should be able to fairly settle cases. Then  
2 they give their estimate of the range. They go on, though,  
3 and say, first, historical values have undergone significant  
4 changes during the period pre- 1982 to the present time.

5 Just so the jury understands, when Manville filed  
6 bankruptcy in 1982, litigation against it stopped, correct?

7 A. That's right.  
8 Q. So the Pre-C claims had been sitting there waiting for,  
9 by the time Trust opened its doors, at least six years?  
10 A. Yes.  
11 Q. In many cases longer?  
12 A. Yes.  
13 Q. Then it continues. It is evident that historical values  
14 can be applied in boilerplate manner to Pre-C cases. They are  
15 useful to point of comparison to the goals of the Trust's  
16 payment of the fair value in light of the reorganization.  
17 You saw this text in the process of forming your  
18 opinion, Doctor?  
19 A. Yes, I did.  
20 Q. More importantly, there's a reference here to then  
21 current state of affairs. Did you read this, Doctor?  
22 Second, the market share has been set since the 1970s  
23 when all asbestosis- containing product manufacturers ceased  
24 the production and sale of such products. This share has been  
25 adjudicated in only a few jurisdictions and at this stage in

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1 the litigation may be nearly impossible to determine  
2 accurately. However, there is knowledge that the Manville  
3 market share would have ranged nationwide from 0 to 40 plus  
4 percent.  
5 You saw this in the context of forming your opinions  
6 in this case, correct?  
7 A. Yes, I did.  
8 Q. You know something about the way asbestos litigation  
9 works, don't you, Dr. Dunbar?  
10 A. I believe so.  
11 Q. And you know that market share is often determined with  
12 respect to a particular job site, shipyard, power plant?  
13 A. Yes.  
14 Q. And the market share in those circumstances is driven by  
15 what kinds of proof have been provided as to which  
16 manufacturer's products were present in that facility or site  
17 over which periods of time?  
18 A. That's right.  
19 Q. So you expect to see substantial variation in market  
20 share from site to site, correct?  
21 A. Yes.  
22 Q. And in some places certain manufacturers will have  
23 predominant shares and other places not?  
24 A. In local -- if you're talking about very localized  
25 conditions, such as a particular site as opposed to a larger

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1 geographic area, I would say that's quite possible.  
2 Q. Let's turn back to the document. It goes on to say that,  
3 most Pre-C cases will be evaluated based upon the Manville  
4 Share. You see that?  
5 A. I've lost you.  
6 Q. Right here (Indicating.)  
7 A. Yes.  
8 Q. Now, as a matter of fact, you looked at roughly a third  
9 of the Pre-C files?  
10 A. Yes.  
11 Q. And that wasn't any kind of random sample, the Pre-C  
12 files, was it?  
13 A. For my purposes it was.  
14 Q. Well, you were provided files by counsel, correct?  
15 A. My --

16 Q. You don't know any more than that?  
17 A. I do know a little bit more than that, yes.  
18 Q. You're representing to this jury it was a random sample  
19 of claim files?  
20 A. I'm saying that for my purposes it was a random  
21 sampling. In other words, there was nothing in the  
22 acquisition of those cases to suggest bias.  
23 Q. But it wasn't a random sample?  
24 A. It was an unbiased sample, from my standpoint.  
25 Q. Now, the document goes on to describe various things that

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1 the Trust can do. Now, one of the things is describes is a  
2 green card or pleural registry system?  
3 A. Yes.  
4 Q. You know what that is, don't you?  
5 A. Yes.  
6 Q. Could you describe that to the jury, please.  
7 A. One of the issues that came up early in asbestos  
8 litigation was that somebody who became diagnosed as having a  
9 pleural plaque might not have been able to sue to get damages  
10 because they were not impaired, they could still function as  
11 they had been doing before.

12 The problem arose that if there was some later date,  
13 ten to twenty years down the road, when they got lung cancer,  
14 then they would truly be impaired and they -- and they would  
15 be due a claim but for the problem that the statute of  
16 limitations might have started running from the time that they  
17 discovered their illness.

18 So this seemed manifestly unfair, the person finds  
19 that they have got an asbestos condition and they can't -- if  
20 they sue at that time, they are not going to get any money,  
21 and if they wait until some later date, they are not going to  
22 get any money.

23 So a device was developed called pleural registries,  
24 where a person who got a pleural condition was registered and  
25 that tolled the statute of limitations.

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1 If it ever came to pass in some jurisdiction, if that  
2 person got a compensable disease, there was no defense against  
3 paying them based on statute of limitations, and they would  
4 get paid.

5 Q. But as a matter of fact, the Manville Trust never used a  
6 green card or pleural registry, did they?

7 A. That's correct.

8 Q. The document goes on to say, under heading how the  
9 process will work. Given approval of the strategy for  
10 valuation discussed above -- you see that?

11 A. Yes.

12 Q. They talk about their objective of settling the 17  
13 thousand claims?

14 A. Yes.

15 Q. And again, there was no pleural registry ever created?

16 A. Not to my knowledge, no.

17 Q. So this is the document you shared with the jury. You  
18 didn't show the jury the final of this?

19 A. I'm not sure whether we showed them the final or not.

20 Q. And on the basis of that document, you assumed that  
21 Manville should have achieved a ten to twenty percent share?

22 A. No, that's not correct. I had other evidence, it just  
23 wasn't shown to the jury.

24 Q. Do you have any document that states categorically that

25 Manville will pay no more than 20 percent?

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1 A. Well, no, in fact they didn't. What I was saying was  
2 that an estimate of the Manville Share in aggregate would have  
3 been in the ten to twenty percent range.

4 There is more than that document to support that  
5 position. In any particular case it might have been 10  
6 percent, in another case it might have been 40 percent, but  
7 the average should have been 20 percent. That's my point.

8 Q. And at this point in time Manville had been out of the  
9 tort system for six years?

10 A. Yes.

11 Q. So they lacked direct personal experience as to how they  
12 would do in sitting down to negotiate cases?

13 A. Well, the claims negotiators hadn't been out of the tort  
14 system for six years. Both Healey and Smith, who were the two  
15 primary claims negotiators, had come over from the ACF.

16 Q. But they hadn't been negotiating on behalf of Manville?

17 A. That's correct.

18 Q. Let's look at GZ 200364. As part of the first TDP, I  
19 believe you told us that a gentleman named Mark Peterson was  
20 serving as a consultant?

21 A. Yes.

22 Q. And Dr. Peterson wrote a memorandum in April of 1991. Is  
23 this something you reviewed in the course of forming your  
24 opinions?

25 A. Yes, I did.

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1 Q. And Dr. Peterson is also an expert in mass tort matters,  
2 correct?

3 A. That's correct.

4 Q. As a matter of fact, you've been in cases, both against  
5 him and with him before?

6 A. That's correct.

7 Q. He writes this analysis in '91, and he makes some  
8 observations about Manville Share. Did you consider this  
9 observation: "We cannot make a definitive current calculation  
10 of the Manville share because co-defendants maintain the  
11 confidentiality of their settlements."

12 A. Did I consider that?

13 Q. You were aware of that; it's hard to get market share  
14 data?

15 A. Well, I'm aware of the problem. I'm not sure that it was  
16 a -- I think the problem is that both Mark and I have market  
17 share data. It's just that it's private. It's under -- it's  
18 confidential, and so you can't really --

19 Q. You can't share it?

20 A. Right, you can't publish the information very easily.  
21 But he and I are, I think we have access market share data.

22 Q. You see here, you were aware that he calculated that  
23 Manville had paid a 30 percent share?

24 A. That's correct.

25 Q. And nowhere in this document, Dr. Dunbar, does he

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1 criticize Manville for having done that, does he?

2 A. No, I don't believe he does.

3 Q. As a matter of fact, he finds under certain circumstances  
4 Manville may have paid less than 30 percent, correct?

5 A. You mean depending on how you estimate the share? He  
6 took out the 85 percent --



7 Q. The Manville only claims.  
8 A. That's his definition of Manville only.  
9 Q. Is that the definition you use?  
10 A. What he did is he took out both 85 percent on one  
11 calculation and 100 percent on the other in order to see if  
12 you had a different definition of Manville only, if that  
13 affected the Manville Share.  
14 I don't have an opinion on whether one of those or  
15 the other is the best way to do it.  
16 Q. He concludes on page 4, indeed, it is likely that the  
17 Manville Trust actually averaged less -- and I'm supplying the  
18 missing text, there's a hole there -- less than 30 percent of  
19 the payments for these pre-bankruptcy claims, and he talks  
20 about the fact that other later co-defendants' settlements  
21 would reduce the Manville Share.  
22 I don't think he talks about it right there but in  
23 this memo he does.  
24 A. Sorry. Let me try to take a look at that if I can.  
25 Yes. But that wouldn't affect my calculations.

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1 Q. So you have the Pre-C settlement plan and that, in your  
2 view, supports the idea of a 20 percent share, I guess you  
3 also say, anticipated or estimated 20 percent share in the  
4 aggregate?  
5 A. Yes.  
6 Q. You're not talking about individual claims?  
7 A. Not talking about any individual claims, right.  
8 Q. I'm going to show you GZ 200053. This is a Trust  
9 document for people doing claims work. It says, a detailed  
10 explanation of market share will be required only for unusual  
11 market share authority requests. Unusual is defined as higher  
12 or lower than the 25 to 35 percent which encompasses the great  
13 majority of Trust values.  
14 You see that, Dr. Dunbar?  
15 A. Yes.  
16 Q. So at this time they were defining claims outside that  
17 range as unusual, if you were in the 25 to 30 percent, that  
18 was a usual or typical value?  
19 A. I agree that later on it had been negotiated up past the  
20 20 percent mark.  
21 Q. I think you talked some about Mr. Smith and his  
22 testimony?  
23 A. Yes.  
24 THE COURT: How much longer is this going to take?  
25 MR. STENGEL: I've got probably another hour and a

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1 half, your Honor.  
2 THE COURT: You do. We'll break for lunch. Be back  
3 at two, please.  
4 (Jury leaves the courtroom.)  
5 THE COURT: Any applications?  
6 MR. BERNICK: I suppose we should take up the  
7 question of the deposition of Dr. Harris at some point.  
8 THE COURT: You said you didn't want to take his  
9 deposition.  
10 MR. BERNICK: Well, the way that you put the  
11 question to me suggests that I ought to seriously consider  
12 that.  
13 My hesitation is very simple. It may be something  
14 where the court can provide some assistance. I would like to  
15 take Dr. Harris' deposition. The problem is that every time

16 we set up an opportunity for discovery, what happens is we  
17 walk into the deposition and all of a sudden the work gets  
18 expanded even more.

19 Then if I ask a question, well, I have had the  
20 opportunity to ask the questions. If I don't ask the  
21 questions, well, I should have asked the questions. I really  
22 believe that this is a situation where the problem is not of  
23 our manufacture and we should not be the ones to bear the  
24 burden from it.

25 He's going to testify about CPS-II, he's going to

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1 testify about the jump in the data in 1962 based upon the NHIS  
2 analysis, I guess, and if he's going to talk about in general  
3 terms he feels that the underlying --

4 THE COURT: He looked at those documents, and I'm  
5 going to let him testify about what he found. He's a medical  
6 doctor as well as a statistician --

7 MR. BERNICK: I don't believe he looked at the  
8 documents. What he says he looked was at raw data. It was  
9 not the underlying files themselves.

10 THE COURT: That was not my impression.

11 MR. BERNICK: It's not the underlying data. It's a  
12 different dataset --

13 THE COURT: Excuse me. If he looked at data which  
14 was available, I'm going to allow it. If he looked at new  
15 data, of course I'm not.

16 MR. BERNICK: The record I believe is absolutely  
17 unequivocal that we did not have what he put his eyes on. You  
18 say we had it. We did not have it. I can't cross-examine him  
19 with respect to that underlying data.

20 MR. STENGEL: Our records indicate they had it. We  
21 will provide them the codes and identify --

22 THE COURT: You want to take his deposition, take  
23 it. He is going to testify.

24 MR. BERNICK: The question, your Honor, really is  
25 what is he going to be permitted to testify about?

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1 THE COURT: He's going to be permitted to testify on  
2 every element that he was challenged by Dr. Wecker.

3 MR. BERNICK: What is it, your Honor, that enables  
4 us to know -- I'm not intending to quarrel with the court --

5 THE COURT: I can't try your case. I have already,  
6 I believe, probably interceded too much, because I have a  
7 great respect for you and you seem upset, and I don't like any  
8 lawyer in my courtroom to be duly upset.

9 MR. BERNICK: I'm sorry if I seemed upset, your  
10 Honor. What I'm trying to do is to solve a problem. The  
11 problem is, we now have an expert who has done further work in  
12 this case.

13 It's an expert who has demonstrated his willingness  
14 and ability to do voluminous amounts of work, and we are  
15 absolutely incapable of doing the same amount of work and  
16 respond to it in time to conclude our case.

17 THE COURT: I can't give you any more detailed  
18 analysis of what he's going to say.

19 MR. BERNICK: I guess what I would like is the  
20 answer to two things that might be helpful, and I don't mean  
21 to offend the court.

22 Number one, with respect to the POC opinions that he  
23 has, we have these computer files that he turned over last  
24 night. As I understood your Honor's inclination this morning,

25 he was --

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1 THE COURT: Those parts that Dr. Wecker says will  
2 take him months to analyze, those runs I don't want him to  
3 testify to.

4 MR. BERNICK: So there will be a general opinion  
5 about whether the new information or the old information that  
6 he has seen supports his views, but we're not going to get  
7 into the computer run?

8 THE COURT: That was my impression this morning.  
9 Yes. I don't know enough about the background or the science  
10 to give you more direction at this point.

11 MR. BERNICK: The matters that he listed were three  
12 that we have talked about. Those are the only ones as to  
13 which we have received now any material at all. Will that be  
14 it?

15 THE COURT: If you haven't received the material by  
16 today, up to this point, I won't permit him to testify, yes.  
17 We have to have an end to it.

18 MR. BERNICK: Then we will proceed to take the  
19 deposition. We would like the deposition to take place here  
20 in New York at our convenience.

21 We're getting ready for closing arguments in this  
22 case, and it's very important that --

23 THE COURT: Try to work it out. He is a human  
24 being, besides being a scientist, and I'm sure he has problems  
25 at home.

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1 MR. BERNICK: We still do not have the Trust's  
2 numbers in this case.

3 THE COURT: I understand.

4 MR. BERNICK: Thank you.

5 THE COURT: All right. Thank you. I will see you  
6 at two.

7 (Luncheon recess.)  
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1 A F T E R N O O N S E S S I O N

2 (Jury not present.)

3 THE COURT: I must say -- I am not saying this  
4 critically of the cross-examination -- sit down, please -- but  
5 I don't understand where it is going. I don't understand what  
6 all of this talk about whether the tobacco portion was

7 considered or not considered. That's not the theory, as I  
8 understood it, of the case.  
9 MR. STENGEL: It is not.  
10 THE COURT: As I understood the theory of your case,  
11 it was that there were more serious and more claims. So the  
12 fact that the tobacco is in or out, as far as I can see, it  
13 has nothing to do with it. It is a lot of smoke, as far as I  
14 can see.  
15 MR. STENGEL: That's our view.  
16 THE COURT: There is one part of the case that was  
17 gone into on direct, and the witness did direct his attention  
18 to it. That is, the question of whether the number and  
19 seriousness of the claims were affected.  
20 I have no view about it, but I don't want  
21 cross-examinations that have no bearing, if they don't. But  
22 you can do whatever you wish with your cross-examination.  
23 (Jury present.)  
24 THE COURT: All right. Proceed, please.  
25 MR. STENGEL: Thank you, Your Honor.

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1 Good afternoon, ladies and gentlemen.  
2 EXAMINATION CONTINUES  
3 BY MR. STENGEL:  
4 Q. Doctor Dunbar, how are you?  
5 Before we move off the subject of your market share  
6 premiums, let me ask you a couple of questions about the  
7 analysis that Doctor Peterson did in 1991. Do you remember  
8 that?  
9 A. Yes.  
10 Q. All right. At the time Doctor Peterson wasn't working  
11 for any party, was he?  
12 A. That's correct.  
13 Q. And he was closer in time to events than you certainly  
14 are sitting here today, is that correct?  
15 A. Closer in time, yes.  
16 Q. So you don't as you sit here today have any reason to  
17 take issue with Doctor Peterson's calculation of a 30 percent  
18 or lower market share for Manville, do you?  
19 A. Well, I don't have reason to take issue with his  
20 calculation, but for the fact that in my sample of cases, we  
21 ended up with a higher average.  
22 Q. But from a methodological or other perspective, you can't  
23 as you sit here today point out any deficiency or flaw in what  
24 Doctor Peterson did?  
25 A. I can't do that because methodologically, the memos that

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1 we have from Doctor Peterson don't actually spell out the  
2 methodology.  
3 Q. Okay. I will take that -- you got a different number so  
4 you don't know?  
5 MR. BERNICK: Objection, to the form of the  
6 question.  
7 THE COURT: Sustained.  
8 Q. Doctor Dunbar, just confirming, you don't have any other  
9 calculated basis for your market share premium other than what  
10 you did with the preC and post-C cases?  
11 A. I haven't calculated any other premium than what has been  
12 presented here off of the preC and the post-C data.  
13 Q. Okay. Let's turn to another subject, which is the  
14 so-called smoking discount. We will talk about why that  
15 matters in a moment but let make sure that we are on the same

16 page and on couple of reasonably important issues.  
17 You agree, don't you, Doctor Dunbar, that the effects  
18 of smoking asbestos exposure have a multiplicative effect on  
19 the development of lung cancer?

20 A. Well, I take that as a given.

21 Q. You have actually written that in your book, and unlike  
22 Mr. Bernick, I have opened it.

23 A. I think what I say is that dose response relationship in  
24 lung cancer is multiplicative. By that all I mean is that you  
25 multiply relative risk times background risk to come up with

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1 the overall risk. That is a little different than saying the  
2 asbestos tobacco synergy is multiplicative.

3 Q. Just so there is no mystery, I will mark this as Dunbar  
4 two and at page 109, you in fact write, the effects of smoking  
5 asbestos exposure have a multiplicative effect on developing  
6 lung cancer; is that correct?

7 A. Yes.

8 Q. You also give an attributable risk to smoking of 80  
9 percent, correct?

10 A. That could be. I don't remember.

11 Q. And the question I have for you, Doctor Dunbar, and the  
12 one that I would like to share with the jury is, you put up  
13 some graphs and -- let me withdraw that.

14 You understand that the theory of the plaintiffs'  
15 case is that by virtue of conduct of the tobacco companies,  
16 the Trust is faced with more and sicker claimants, correct?

17 A. Yes.

18 Q. Let me -- and I would -- with apologies to defendants, I  
19 have marked up one of your overheads, and you posit this world  
20 with these people who smoke and you have asbestos. But all --

21 THE COURT: What number is that you are putting up?

22 MR. STENGEL: We will call this Dunbar three, Your  
23 Honor.

24 THE COURT: It had better be Dunbar plaintiff two and  
25 Dunbar plaintiff --

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1 MR. STENGEL: It is plaintiffs' Dunbar three, Your  
2 Honor.

3 THE COURT: Yes.

4 Q. Now, you explained, I think, how an aggregate number  
5 would work, but I want you to do what economists do, which is  
6 hold everything else equal and if you assume we have the TDP  
7 in place and you assume that hypothetically, although it is  
8 not a real number, lung cancers are being paid twelve thousand  
9 five hundred dollars each.

10 A. Okay.

11 Q. And the expectation was that these eight claimants would  
12 arrive at the Trust and my question is very simply, if  
13 claimants nine through one hundred arrive and the Trust is  
14 still paying each claimant twelve thousand five hundred  
15 dollars, what does each of the additional claimants cost the  
16 Trust?

17 A. I'm -- each additional claimant costs the Trust in this  
18 world twelve thousand five hundred dollars.

19 Q. Thank you.

20 You talked briefly this morning about claims under  
21 the TDP, that there were certain claims that you didn't think  
22 were adequately documented?

23 A. Yes.

24 Q. I would like to discuss that with you, if we can.

25                   You put up a chart with a series of doctor's names

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1    and some percentages?

2    A.    Yes.

3    Q.    The source of that chart was a single letter from Mark  
4    Ledderer to Elihu Inselbuch.  That was a letter written in  
5    1998?

6    A.    Sounds right.

7    Q.    We will mark this as plaintiffs' Daubert four, or Dunbar  
8    four, excuse me.

9               In this letter, -- well, first of all, Mr. Ledderer  
10   describes the process as being downgraded because of their  
11   X-ray results?

12   A.    Correct.

13   Q.    Which means they got paid less?

14   A.    Paid -- got paid less, if anything.

15   Q.    Some of them didn't get paid anything at all?

16   A.    Correct.

17   Q.    In fairness to Mr. Ledderer, his analysis was described  
18   as my analysis has been briefly discussed with the staff at  
19   the Trust, but my methods are now and have not yet been  
20   replicated.

21               You see that, sir?

22   A.    Yes.

23   Q.    He talks about unclarity about what's going on and he  
24   says there may be no doctor bogus, outright fraud, something  
25   very much more complicated going on.

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1               This was a preliminary assessment of Mr. Ledderer,  
2   correct?

3   A.    I am not exactly sure the part that I used would be  
4   called preliminary.  I think the part that I used had been  
5   substantiated in terms of the numbers since 1995.

6   Q.    Well, the numbers you used related to an assessment of  
7   what's called B-reader invariability, correct?

8   A.    Yes.

9   Q.    That means in the -- the jury I think has heard a little  
10   bit about ILO score and X rays, probably more than they want  
11   to, in that sense what was being analyzed was how often the  
12   doctors you listed for the jury match other B-readers,  
13   correct?

14   A.    Matched one out of two, yes.

15   Q.    And are you aware of the study commissioned by the Trust  
16   from Penn State University assessing the fairly high degree of  
17   B-reader invariability that exists?

18   A.    I am very aware of that study and it said that with  
19   regard to doctors, this is an accurate approach.

20   Q.    And you are aware that the Trust took steps to press  
21   forward with medical audit and ultimately determined that the  
22   medical audit was not adequate for their purposes?

23   A.    Well, I would dispute the characterization.

24   Q.    Well, did you look at documents sent to the Trust by  
25   people outside the Trust, like plaintiffs' lawyers, about the

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1    B-reader issue?

2    A.    Yes.

3    Q.    And as a settlement trust, the Trust has to take into  
4   account the views of those people, correct?

5    A.    I think that's a sweeping generalization.  I wouldn't  
6   necessarily go along with that.

7 But I think the optimal trust design is one where you  
8 go along with them up to an extent but where one group of  
9 plaintiffs' attorneys are disadvantaging say the future  
10 claimants, then I don't think you do go along with them.

11 Q. You yourself are not an expert in evaluation of ILO  
12 scores or X-ray review?

13 A. That's correct.

14 Q. Do you have -- strike that.

15 So you did this entire calculation, the only  
16 quantification you have re problem with claims in the TDP,  
17 based on the attachment to Mr. Ledderer's letter?

18 A. The -- yes. The quantification is -- comes from that  
19 data. But it is verified by a lot of other data that I have  
20 seen.

21 Q. Okay. It was based solely on Mr. Ledderer's description  
22 of the results of that subset of documents?

23 A. Again, the quantification comes from that particular  
24 letter.

25 Q. You didn't do any quantification of issues relating to

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1 the conduct of the Trust under the TDP?

2 Strike that.

3 You actually think the Trust is fairly effective  
4 under the TDP, correct?

5 They do a pretty good job of processing?

6 A. Would I say that?

7 Q. Yes.

8 A. Well, I think they're efficient at handling the claims.  
9 I think they handle way too many because of the design.

10 Q. The design being the disease criteria of the TDP?

11 A. The relative to say design such as came out of the  
12 Georgine settlement which I think is a much better design for  
13 handling claims.

14 Q. But in fact the Manville Trust has become a model for  
15 other asbestos facilities, has it not?

16 A. To an extent.

17 Q. Well, Doctor Dunbar, let me show you what we will mark as  
18 plaintiffs' Dunbar five which is, for the record, the  
19 disclosure statement with respect to the Celotex bankruptcy  
20 and I have marked annex B, Doctor Dunbar, and just ask you to  
21 look at the disease criteria that are in the Celotex plan.

22 MR. BERNICK: Your Honor, I object.

23 I think that that is entirely irrelevant and it's  
24 hearsay. It is offered for a purpose or to establish a  
25 proposition that's not at issue through this witness. We are

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1 not arguing, this witness is not here to say that at the  
2 present time the TDP values that were used by the Manville  
3 trust are somehow different from values that are used by  
4 another trust, which is the purpose for which we think this  
5 has been offered.

6 The question is what those values actually  
7 represent. The fact that they are used by another trust  
8 doesn't make any difference so I don't know what the purpose  
9 of that. It goes beyond the scope of the examination. It is  
10 also irrelevant to the case.

11 THE COURT: The witness, as I understood it, has  
12 criticized the operations of the Trust as well as the TDP. He  
13 is being asked to look at this for purposes of veracity.

14 MR. BERNICK: I didn't understand that to be the  
15 proffer of the question. But maybe I didn't hear it

16 properly.  
17 THE COURT: As I understand it.  
18 Q. You can look at the criteria. They are identical, are  
19 they not, to the TDP?  
20 A. Yes, they are.  
21 Q. You know Celotex to be another very substantial asbestos  
22 defendant, at least it was?  
23 A. That's right.  
24 Q. Are you aware that Dean Macchiarola testified in this  
25 court that the medical audit had been abandoned because it was  
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1 not capable of distinguishing adequately between people that  
2 should be paid and people who should not be paid?  
3 MR. BERNICK: I object to the characterization of the  
4 testimony. The testimony could be shown.  
5 Q. This is page 1342 of Macchiarola. Question by  
6 Mr. Bernick:  
7 There is no medical audit. You can't represent that  
8 the TDP claims are bona fide. Can you?  
9 Answer: That's part of our difficulty. The medical  
10 audit was unable to distinguish between bona fide and non-bona  
11 fide claims, no matter what, because the disease was not  
12 susceptible to a foolproof determination.  
13 The medical audit was not, in and of itself, able to  
14 give us the information that would allow us to discard only  
15 claims that were not bona fide. Medical audit would also  
16 eliminate claims that were bona fide. And that's what the  
17 witnesses -- that's what our experts told us when they  
18 examined the medical audit.  
19 Were you familiar with that testimony?  
20 A. Yes.  
21 Q. Doctor Dunbar?  
22 A. Yes.  
23 Q. You have never been a trustee before?  
24 A. No.  
25 Q. You've never been responsible for running a facility that  
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1 has as its obligation the compensation of hundreds of  
2 thousands of claimants?  
3 A. That's fair.  
4 Q. You know that Dean Macchiarola does in fact have that  
5 responsibility?  
6 A. Yes.  
7 Q. I would like to talk to you about this period of time we  
8 moved from preC into the TDP in the negotiations because when  
9 you and Mr. Bernick talked about the transition, there were  
10 some values or language I think was omitted.  
11 You don't dispute that the criteria and values in the  
12 TDP are reflective of not only historical value but what was  
13 happening in the court system?  
14 A. I would agree with that.  
15 Q. So it's not just historical value?  
16 A. Right. I think I mentioned the issue with the pleural  
17 values to show that.  
18 Q. If we were to look at the TDP, and I am referring to  
19 plaintiffs' 75500.018, and if we look at category two,  
20 non-disabling bilateral interstitial lung disease. I will put  
21 this here, so you have it in mind.  
22 Now, nothing in the TDP -- you need to see the rest  
23 of the -- right here.  
24 Would you like to see the rest of the criteria? I



25 would be happy to turn the page for you.

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1 A. I just need the question.

2 Q. There is no reference under category two or any  
3 consideration of smoking, is there?

4 A. That's correct.

5 Q. So smokers and non-smokers get paid exactly the same  
6 under category two?

7 A. In the TDP.

8 Q. In the TDP.

9 If we were to look at category three, which is  
10 disabling, that's also true, isn't it?

11 A. Yes.

12 Q. And if we turn to categories five and six, while smoking  
13 is considered the -- you can't take issue with the fact that  
14 of the Manville Trust claimants approximately 85 percent of  
15 those claimants qualified in category six, which is the more  
16 expensive category?

17 A. That's correct.

18 Q. Leaving rationally 15 percent in the lower value  
19 category?

20 A. That's right.

21 Q. You are also aware, are you not, that 80 to 90 percent of  
22 the Manville Trust clients are -- claimants smoke?

23 A. That sounds about right.

24 Q. So functionally, the distinction between categories five  
25 and six is clearly not a smoking discount, correct?

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1 A. I would disagree with that.

2 Q. But do you know whether there is a statistically  
3 significant difference between what non-smokers and smokers  
4 receive under the TDP?

5 A. Well, I've never tested that, no.

6 Q. So you can't say as you sit here today?

7 A. No.

8 Q. Now, I want to talk to you about this notion of an  
9 aggregate discount for smoking in the TDP. I think you have  
10 told us that -- well, certainly -- strike that.

11 There is no discount at all in the TDP for the two  
12 categories of bilateral interstitial disease, correct?  
13 Explicit in the TDP?

14 A. Well, the -- there are two different issues there. There  
15 is a discount for smoking because it is based on historical  
16 values. But if you are a smoker and you come to the TDP,  
17 smoking is not a criteria for either the 25,000 or the \$50,000  
18 claim.

19 My point is that the reason they are 25,000 and  
20 50,000 is because smoking reduced the average value of  
21 asbestosis claims prior to the TDP.

22 Q. Let's talk about the derivation of your average value.  
23 That's your measuring stick here.

24 That, again, was calculated from the 591 claims as to  
25 which you had the CAS forms?

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1 A. I think that's seven hundred claims, actually.

2 Q. All right. Well, how many non-smoking lung cancer claims  
3 did you have for the preC period -- pre and post-C period in  
4 the sample of claims that you used to calculate these  
5 averages?

6 A. I don't know the number offhand.

7 Q. Let me hand to you, if I can find it, something which I  
8 think would refresh your recollection.  
9 I will mark this Dunbar six, plaintiffs' Dunbar six.  
10 I draw your attention to the second page of the  
11 exhibit, doctor.

12 A. You want me to count these?

13 Q. It looks like ten to me.

14 A. That's correct.

15 Q. So all of your -- this is as to lung cancers?

16 A. Correct.

17 Q. All of your calculation of averages and projections and  
18 comparisons between smokers and non-smoking lung cancer  
19 claimants relies on ten non-smokers for the entire pre-TDP  
20 period?

21 A. No, that's incorrect.

22 Q. Isn't this the basis of the average you have calculated  
23 and presented to this jury?

24 A. No.

25 As I have pointed out I think in -- I'm sorry if I

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1 wasn't clear, what we came across was the Peterson averages or  
2 the Peterson recommendations of the seventy thousand versus  
3 the one hundred and twenty thousand. So that -- those were  
4 the numbers that were being offered in the TDP process.

5 We then went through and calculated our own averages  
6 from the data that were available in the sample that the  
7 plaintiffs in this case had drawn and we verified the Peterson  
8 averages with that sample.

9 Now, also with regard to things like the average  
10 discount for smokers, off of the CAS forms, again, that's a  
11 five hundred and ninety sample. That's not a sample of ten.  
12 With regard to the correlation, again, that's another large  
13 sample. That's a five hundred ninety sample.

14 A lot of the calculations are based on much larger  
15 samples than that.

16 Q. Doctor, you went somewhat beyond my question.

17 My question was, and this is in fact a listing of the  
18 claims as to which you have CAS forms, is that correct?

19 A. For which we have both CAS forms with recommended amounts  
20 and paid amounts.

21 Q. Right.

22 So although there may have been larger samples to do  
23 other things, when you did your calculation of averages, not  
24 when you looked at Doctor Peterson's estimate, when you did  
25 your calculation, all of your calculation of averages used ten

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1 non-smoking cases?

2 A. Right, but the --

3 Q. Simple question.

4 A. It is an average that includes -- the seventy-three  
5 thousand average, okay, that includes -- I think that's  
6 something on the order of seven hundred, and in that seven  
7 hundred there are ten non-smokers.

8 Q. I am just looking at the comparison between smoking and  
9 non-smoking.

10 When you get your eighteen thousand five hundred  
11 number you point to as giving consistency with what Doctor  
12 Peterson indicated was a midpoint expectation, that  
13 eighteen-five comes separate off this list of ten cases,  
14 correct?

15 A. That is exactly precise.

16 Q. Right. That's what I was trying to do.  
17 So again, your average, the eighteen-five you have  
18 shown to the jury this morning, relies on ten cases out of  
19 27,000 cases resolved in the preC period or preTDP?  
20 MR. BERNICK: I think he's answered that question.  
21 He's also answered it in the proper context.  
22 THE COURT: Next question, please.  
23 Q. Now, Doctor Dunbar, we talked a little this morning about  
24 the negotiations in the TDP and the various groups that were  
25 involved. Do you remember that conversation?

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1 A. Yes.  
2 Q. And we also talked this morning about the fact that in  
3 the preC and post-C period, there were negotiations going on  
4 between plaintiffs and defendants, and the discounts that you  
5 claimed to have identified in the pre-TDP period, if you had  
6 lung cancer and were a non-smoker, you won't get a smoking  
7 discount, would you?  
8 A. No.  
9 Q. Now, you come in here and posit a very different outcome  
10 for non-smokers under the TDP, correct?  
11 If you're an asabestotic who doesn't smoke, you get a  
12 discount, right?  
13 A. Yes.  
14 Q. All right. And with all of the time and effort that went  
15 into the negotiation of the TDP, have you seen any piece of  
16 writing or testimony or notification suggesting that  
17 claimants, that even if they're non-smokers they are going to  
18 suffer a smoking discount?  
19 A. Under the TDP?  
20 Q. Yes.  
21 A. No. That would be an irrelevant question.  
22 (Continued on the next page.)  
23  
24  
25

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1 BY MR. STENGEL:  
2 Q. Okay.  
3 A. Before BID, smoking is not part of the criteria.  
4 Q. Right.  
5 A. My point is that the BID values have been brought down by  
6 the smoking discount that occurred prior to the TDP.  
7 Q. But you presumed that the TDP was negotiated by lawyers  
8 who had nonsmoking clients, correct?  
9 A. I'm sure they had some.  
10 Q. Wouldn't you expect those people to object if their  
11 clients were getting secret discounts forced on them?  
12 A. I suspect that there were all kinds of clients who were  
13 disadvantaged by the TDP because, for example, they might be  
14 from a jurisdiction, such as Mississippi, where they would get  
15 higher claims values. They may have had more dependents.  
16 They may have been younger.  
17 There's a lot of reasons why people would have had  
18 higher, sometimes much higher, claims values than are on the  
19 matrix. But the Trust made a decision to simplify things and  
20 one of the simplifications was that there were only seven  
21 values.  
22 Q. My question is really more simple, Dr. Dunbar.  
23 You've given the jury references to some documents  
24 that talk about historical values in the TDP?

25 A. Yes.

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1 Q. You've shown them that the numbers, at least in raw  
2 terms, the way you calculate them, seem to correspond?

3 A. Yes.

4 Q. But you would admit that imposing an overall smoking  
5 discount on every Trust claimant would be a substantial change  
6 from the world before the TDP, correct?

7 A. You have to tell me what you mean by substantial.

8 In the case of asbestos, it's a 14 percent change.

9 And in the case of lung cancer there's still a smoking  
10 discount.

11 Q. But that would matter to claimants, wouldn't it?

12 A. Yes, it would matter to claimants. It would matter to  
13 any claimant that they think has a better claim than a TDP  
14 value.

15 Q. And all I'm asking is other than references to historical  
16 value and the numbers eyeballing the same way, can you point  
17 us to a piece of paper, memorandum or letter, that says  
18 there's a secret discount under the TDP for smokers?

19 A. No. Nobody said that directly.

20 Q. And you can't cite any negotiations where that issue was  
21 specifically discussed?

22 A. The smoking issue?

23 Q. Right.

24 A. I don't recall anything.

25 Q. So, we move from an environment where only smokers got

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1 discounts to one where everybody gets a discount and nobody  
2 says anything about it?

3 A. Well, again, nobody said anything about the very young  
4 people that get paid or the people with six dependents.  
5 There's a lot of people who were disadvantaged by the TDP and  
6 a lot of people who got a benefit from it.

7 Q. Let me ask you one other question about smoking and its  
8 significance.

9 You wrote something before your book on estimating  
10 future claims?

11 A. Yes, I did.

12 Q. That was written in 1992?

13 A. Yes.

14 Q. And that was written before you were retained by any  
15 tobacco company?

16 A. Yes.

17 Q. And when you did the analysis that's reflected in here  
18 you talked about valuing asbestos claims?

19 A. Yes.

20 Q. And you even presented the results of a regression  
21 analysis that you had done, correct?

22 A. Yes.

23 Q. And in the course of presenting that regression analysis  
24 you shared with the reader the six variables that were  
25 important to determining value under the regression analysis,

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1 correct?

2 A. That's correct.

3 Q. And those variables were age, occupation, disease,  
4 jurisdiction, share of settlement and year of filing, correct?

5 A. Yes.

6 Q. And nowhere in that list created before you were retained

7 by a tobacco company is there any reference to smoking being  
8 an important variable, as the Nera regression analysis, to  
9 determine the value of asbestos claims, correct?

10 A. That's correct. I can explain if you want.

11 Q. I think we understand.

12 MR. STENGEL: Nothing further, your Honor.

13 THE COURT: Thank you.

14 Make your redirect very brief, please.

15 MR. BERNICK: I'm sorry.

16 THE COURT: Very brief, please.

17 MR. BERNICK: Okay.

18 REDIRECT EXAMINATION

19 BY MR. BERNICK:

20 Q. To save time, Dr. Dunbar, on the question of more claims  
21 and more severe claims, I want to mark DEM 012137 and 38 and  
22 ask you whether those are the charts that Mr. Stengel marked  
23 up and we'll just offer them into evidence instead of taking  
24 further time.

25 MR. BERNICK: DEM 012137 and 8.

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1 THE COURT: And 8; 38 or 8?

2 MR. BERNICK: 37 and 38.

3 THE COURT: Okay.

4 MR. BERNICK: We'll offer them in and we can argue  
5 from them later on.

6 (So marked.).

7 Q. The whole question that was raised by the Dr. Harris  
8 model, what if there were less smoking would there be less  
9 severe and fewer claims, that's the counter factual world  
10 question Mr. Stengel asked you about that. In point of fact,  
11 have you done a whole analysis of what would happen if there  
12 were actually less smoking?

13 A. Yes, I have.

14 Q. And if there were less smoking, the discount would have  
15 been smaller?

16 A. The discount would have been smaller, so the average  
17 values would have been higher.

18 Q. Then what would happen to the volume of claims?

19 A. The volume of claims goes down if there's less smoking.  
20 No doubt about it.

21 MR. STENGEL: Your Honor, this is not redirect. This  
22 is a whole new line of questioning.

23 THE COURT: No. You can ask one or two questions  
24 and then move on.

25 A. The volume of claims would go down if there's less

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1 smoking. But because each claim is now being settled for a  
2 higher amount, because there is less smoking, the total amount  
3 that the Trust pays now is equivalent to what the Trust would  
4 pay if there was less smoking and that's an evaluation which I  
5 did.

6 Q. Mr. Stengel asked you whether in your book you put down  
7 the attribute risk from smoking for asbestos workers -- was it  
8 eighty percent?

9 A. That's what he said.

10 Q. At the present time, even if you assume that tobacco were  
11 eighty percent of the problem, has the Manville Trust even  
12 come close to paying the 20 percent that would be theirs?

13 A. No.

14 Q. You were asked about the medical audit and somehow  
15 whether the medical audit was resolved.

16           Actually, you were asked about problems of  
17 variability in the ILO as being one of the things that was  
18 uncovered in the medical audit. Is variability in the ILO a  
19 tobacco problem or an asbestos Trust implementation problem?  
20 A. Well, in this case, it's an implementation problem.  
21 Q. The problems that were noted in the TDP through the  
22 medical audit, counsel brought out that well, somehow, the  
23 medical audit no longer was followed by the Trust. Were the  
24 problems that gave rise to the medical audit -- did they ever  
25 go away?

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1 A. No.  
2 Q. Is that what you have tried to analyze?  
3 A. Yes.  
4 Q. It was brought out that there are a huge number of claims  
5 in the TDP compared to the small number of claims earlier.  
6 Does that change any part of your analysis at all?  
7 A. No. The sample sizes that we have are really pretty  
8 large, given modern day statistical methods.  
9 Q. All the sample sizes that were referred to, are they  
10 statistically significant samples?  
11 A. Yes.  
12 Q. And the 300,000 claims, the fact that there are 300,000  
13 claims, does that say that the system is working well or  
14 poorly or can can't you tell?  
15 A. Just by saying the number 300,000 you can't tell one way  
16 or another. You do have to go in back of the numbers to find  
17 out what's going on.  
18 Q. You were asked some questions about the tort system  
19 values. You testified that there was the historical values  
20 that were then carried over to the scheduled values and the  
21 TDP and you were asked on cross-examination, didn't the tort  
22 system play a role as well.

23           Could you just tell us exactly in what respect the  
24 tort system played a role and whether that has any impact on  
25 your opinions?

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1 A. The reason the tort system played a role was because when  
2 the values were set by the Trust they wanted to prevent people  
3 from opting into what's called individual evaluation. There  
4 are some people who are actually evaluated individually in the  
5 TDP now. What they wanted to do is to set those values at a  
6 level that would kind of prevent that so they couldn't lower  
7 the values or else people would want to go into individual  
8 evaluation. So there was an incentive to use historical  
9 values and market values.

10           As a result of focusing on market values, they  
11 dropped the value of the plural claims below the average.

12 Q. The plural claims?

13 A. Yes.

14 Q. Are the plural claims any part of your analysis of this  
15 case?

16 A. None.

17 Q. There were questions about the TDP schedule itself and  
18 you were asked a bunch of questions about how these categories  
19 relate to one another?

20 A. Yes.

21 Q. Does that have any bearing on the tobacco portion or the  
22 tobacco share that was shaved off by virtue of the aggregated  
23 value of those categories?

24 A. No. If there would have been less smoking those averages

25 would have been higher and the TDP values would have been

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1 higher and they would be paying more today per claimant,  
2 offsetting the decline in the number of claims.

3 Q. Specifically, there were a bunch of questions about what  
4 the prices actually were of these categories and the  
5 relationship between the categories?

6 A. Yes.

7 Q. Does that speak at all to the tobacco share that had been  
8 taken off the top historically?

9 A. No.

10 Q. Does your analysis of the tobacco share and the fact it  
11 was taken off historically -- is that affected at all by the  
12 per pricing questions that were asked by counsel?

13 A. No. You could have one category for the lung cancer  
14 claims and the result would still be the same.

15 Q. You were asked whether the seventy-three is the average  
16 lung cancer claim under the TDP, whether that average was  
17 based on the sample of only ten. I'm not sure you got a  
18 chance to address that flat out. Would you answer that  
19 question?

20 A. That seventy-three thousand is based on a sample of about  
21 700 I believe.

22 Q. Two more quick areas. One directly driven by this. If  
23 you take a look at the period of time, you were asked kind of  
24 about negotiation dynamics. How could it be that if the  
25 discount were actually already in place some people that were

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1 associated with the TDP weren't complaining about it or  
2 questions to that effect, do you recall?

3 A. Yes.

4 Q. From the point of view of negotiation dynamics, if you  
5 are negotiating a new deal, tell us what the significance is  
6 of history?

7 A. What you needed -- what the Trust needed was a matrix  
8 that they could sell to the plaintiffs' bar. That's a direct  
9 quote by the way. And so they needed a matrix that the  
10 plaintiffs' bar could say would be based on some touchstone,  
11 that there was a rationale for the matrix and the rationale  
12 that was built-in were these historical values and as I said  
13 before there was a motivation not to reduce those values  
14 because otherwise people would have opted into individual  
15 evaluation and you wouldn't have gotten the benefits of the  
16 matrix system.

17 You would be back in the evaluating claims  
18 individually like they were doing not post-C period.

19 Q. Before the TDP, is it true that most claimants against  
20 the Trust were smokers?

21 A. Yes.

22 Q. Is it true that before the TDP there was a discount for  
23 tobacco?

24 A. Yes.

25 Q. And tell me whether or not there was a lot of paperwork,

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1 a lot of documents, specifically generated talking about that  
2 discount?

3 A. There were.

4 Q. Under the TDP, is it true that most people are smokers?

5 A. Yes.

6 Q. Is it true that the discount carried forward?

7 A. Yes.  
8 Q. Did you see a single shred of paperwork that said we're  
9 now going to raise the prices in order to pay for tobacco?  
10 A. None.  
11 Q. And given the fact that most people are going to be  
12 smokers, either way, from the point of view of negotiation  
13 dynamics, the 80 or 90 percent of people who are already  
14 smokers, is it going to make a difference to most people that  
15 a discount is simply continuing through?  
16 A. Yes.  
17 Q. One last area.  
18 What was the market share that you calculated that  
19 Manville actually did pay?  
20 A. About 36, 37 percent, in that range.  
21 Q. This 10 to 20 percent market share, as you pointed out,  
22 was estimated at the beginning. Was that solely on the basis  
23 of that one document?  
24 A. No.  
25 Q. In fact, if we want to, can we go to the testimony of  
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1 Greg Smith and find the same market share and the fact that he  
2 thought it was a reasonable estimate?  
3 A. Yes.  
4 Q. If we wanted to go to Trust document 0015077, June 1988,  
5 would we find that Dennis, who is another claims guy, said  
6 that the ACF generally paid 80 to 90 percent of total value on  
7 settlements, which would again leave 10 to 20 percent to  
8 Manville?  
9 A. And of 56 other defendants that are not in the ACF.  
10 Q. If you go to documentation outside of the Trust, is it  
11 true that when settlements were taking place outside of the  
12 Manville Trust that agreements were reached between  
13 non-Manville companies about what the Manville share would be?  
14 A. Yes, that happened.  
15 Q. And when these people, who were not even Manville  
16 Corporation, agreed about what the implicit Manville share  
17 was, was it 30 percent or 40 percent or was it less?  
18 A. 7 to 13 percent in a few cases in 1990.  
19 Q. In more documentation, every time there was a negotiation  
20 in the first instance, every time there was a negotiation, did  
21 the Trust take the position that the market share was between  
22 10 and 20 percent?  
23 A. In the beginning they did, later on it went up. But in  
24 the beginning, in May of 1988, they were doing that.  
25 Q. You were asked whether the fact that the market share  
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1 rose to 30 percent might be due to inflation. Did inflation  
2 drive market share?  
3 A. No.  
4 Q. Why not?  
5 A. Market share doesn't go up with inflation. If there is  
6 inflation then everybody goes up the same amount, so the  
7 market share stays the same.  
8 Q. You were asked, gee, isn't it true, the real market  
9 share, it really was the case, that there was real information  
10 saying that the market share of Manville actually was higher.  
11 Did you see any documentation or any analysis by the Trust  
12 that said, no, the real market share, what Manville really was  
13 responsible for out there in the marketplace, was actually 36  
14 percent or 30 percent?  
15 A. Nothing like that.



16 Q. Let's talk about another possibility, which is that this  
17 rise was caused by negotiation. Is that what you have seen in  
18 all of the documents that you have seen?

19 A. Yes.

20 Q. And if there's negotiation there are people who have a  
21 stronger position and people who have a weaker position in  
22 negotiation?

23 A. That's correct.

24 Q. Can you tell me whether the Trust made a very significant  
25 decision in early 1988 that weakened its negotiation position?

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1 A. It did.

2 Q. What was that decision?

3 A. It became a very motivated negotiator. It's like  
4 motivated buyer or motivated seller. It motivated itself to  
5 try to settle all of the 17,000 pre-C claims before the  
6 consummation of the Trust. Given that they started out in  
7 May, they really had only a few months to do that. So they  
8 were a motivated negotiator. They had to settle things  
9 quickly under the philosophy in which they were working.

10 Q. Was that a decision that was required by the plan of  
11 reorganization?

12 A. No, this was not.

13 Q. Was that a decision that was -- that had anything to do  
14 with tobacco at all?

15 A. No.

16 MR. BERNICK: Nothing further.

17 MR. STENGEL: Nothing.

18 THE COURT: Step down, stir.

19 (Witness excused.)

20 THE COURT: You can take a break.

21 I want Mendelsohn to take the stand.

22 (Jury excused.)

23 THE COURT: Where is the doctor?

24 Oh, she's coming in. I want her out of here today,

25 finished, direct examination and cross-examination.

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1 MR. BERNICK: It's all cross-examination.

2 (Recess.)

3 (In open court; jury present.)

4 SARA MENDELSON, resumed.

5 CROSS-EXAMINATION

6 BY MS. KEARSE:

7 Q. Good afternoon, doctor.

8 A. Good afternoon.

9 Q. I'm going to start off by saying I have a terrible cold  
10 and they tell me I have an accent up here. This is going to  
11 be interesting. It's Friday afternoon. We will try and get  
12 through this quickly because I don't think my voice is going  
13 to last a long time.

14 Doctor, can you see okay? Do we need to move the  
15 screen?

16 A. I think I'm okay.

17 Q. You can see this right here?

18 A. Yes, so far.

19 Q. I would like to start out just a little bit to figure out  
20 where we're going to be going today.

21 THE COURT: Mark that, please.

22 MS. KEARSE: I'm going to mark it Plaintiffs' M 1.

23 Q. Doctor, we're going to be talking about exposure and once  
24 we have exposure you'll agree we can go to a subclinical level

25 before we get to a clinical level?

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1 A. It could occur that way.

2 Q. And then we go down to a clinical level where you can  
3 actually see?

4 A. Where you can make a diagnosis of clinical asbestosis.

5 Q. And then, doctor, I think you said yesterday, even at  
6 times, even after, clinical asbestos-related disease can lead  
7 to death, including asbestosis?

8 A. Not necessarily. In severe cases it may progress to  
9 that.

10 Q. Or just clinical impairment. Okay.

11 Doctor, in between here and here, is that what we  
12 call latency, between the time of exposure and the time we can  
13 actually see the clinical diagnosis?

14 A. From the initial, from the beginning of exposure, until  
15 when a clinical diagnosis is made, that would be the latency  
16 period.

17 Q. We have latency. Okay.

18 (Continued on next page.)

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1 Q. Doctor, you agree with me that in between this period of  
2 time, between exposure and when you're able to see a clinical  
3 diagnosis setting in your office, there's a lot going in  
4 between here in the lungs because of the latency period?

5 A. Certainly there are changes that occur in the lungs that  
6 will eventually cause the clinical disease.

7 Q. Doctor, are you here to say that in between this period  
8 and this period there is no disease?

9 A. There's no clinical disease.

10 Q. Is there any disease at all?

11 A. Well, I wouldn't call it disease. There are changes that  
12 occur in the lungs. There's fibrosis that is occurring.  
13 There is a process that is occurring, but I wouldn't call that  
14 process a disease until it's diagnosed as a disease.

15 Q. Doctor, can someone be sick and die in between here  
16 before you see it, by having a disease process that happened  
17 from exposure to asbestos, a latency period having fibrosis  
18 occur in the lungs and you cannot see it here?

19 A. That wouldn't be very likely for someone to die from  
20 asbestosis before we're able to clinically diagnose it, no.

21 Q. Doctor, I'd like to talk a little bit about your  
22 background. If someone want to go through some of the medical  
23 literature and see some of the articles that you have  
24 published on asbestos, would we find any?

25 A. I have not published on asbestos.

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1 Q. And tobacco?

2 A. I have not published on asbestos.

3 Q. And tobacco and asbestos interaction?

4 A. No.

5 Q. The jury has heard a lot about peer review articles here,  
6 but you're not here today to talk about any peer review

7 articles that you have written on the subject?  
8 A. I have not written any peer review articles on the  
9 subject.  
10 Q. That would include any of your clinical experiences with  
11 asbestos, correct?  
12 A. That's correct.  
13 Q. You've never been part of the Surgeon General's panel of  
14 experts on smoking and health matters?  
15 A. No, I have not.  
16 Q. Any asbestos matters?  
17 A. No. Not on the Surgeon General's reports, no.  
18 Q. Your own university has smoking cessation programs?  
19 A. My university currently does have smoking cessation  
20 programs.  
21 Q. And has taken positions on smoking and health?  
22 A. They have, over the course of time.  
23 Q. And have you been consulted on any of those matters?  
24 A. I have not been involved in any of those matters, no.  
25 Q. I ask you that because, nevertheless, you've asked here,

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1 retained by the lawyers for the tobacco defendants here, and  
2 you will agree with me they didn't find you by going through  
3 the medical literature, correct?  
4 A. That's correct.  
5 Q. In fact, Mr. Schroeder, I believe, someone in his office  
6 asked your brother if he knew anyone who was in occupational  
7 medicine?  
8 A. Well, I'm not sure how it transpired in terms of asking  
9 my brother, but I know that someone in his office was familiar  
10 with my brother, so when I received the phone call, they used  
11 my brother's name --  
12 Q. There's nothing wrong with that.  
13 A. -- to get me on the phone.  
14 Q. Your brother referred you to the lawyers, and you're here  
15 today, correct?  
16 A. Again, I'm not sure exactly how that referral transpired,  
17 but they certainly used my brother's name when I received the  
18 phone call.  
19 Q. Doctor, you have published articles, have you not?  
20 A. Yes.  
21 Q. You published articles on some eye bank issues in Cornea  
22 Magazine?  
23 A. Yes.  
24 Q. You're not a B-reader?  
25 A. No.

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1 Q. I think you said on direct yesterday, you're not -- you  
2 don't perform any ILO interpretations that a B-reader would?  
3 A. A B-reader would perform those interpretations.  
4 Q. You're not here to discuss any relationship between lung  
5 cancer and tobacco smoking or asbestos, right?  
6 A. That's correct.  
7 Q. Doctor, I want to talk about three things that you were  
8 asked to do while you were here. You were asked to review the  
9 literature, and you made some conclusions based on your review  
10 of the literature, correct?  
11 A. That's correct.  
12 Q. And review claim forms?  
13 A. Yes, claim files.  
14 Q. And review the TDP criteria, comment on that?  
15 A. That's correct.

16 Q. Doctor, one of your sources for the medical literature  
17 you reviewed was -- came from Mr. Schroeder's firm; is that  
18 correct?

19 A. Mr. Schroeder's firm did send me a number of articles.  
20 Predominantly, the source of my review, however, was my own  
21 search that I conducted, as well as my own files.

22 Q. Prior to your review of those articles, you did not think  
23 you had conducted an exhaustive review for yourself to write  
24 on the subject matters you're testifying here today to; is  
25 that correct?

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1 A. I would never write an article without prior -- no matter  
2 how familiar I was with the field -- without immediate prior  
3 research of the literature because that's the way one would  
4 write a peer review type of article.

5 So prior to coming here today, I had not conducted an  
6 exhaustive search such that I would sit down and write that  
7 type of article, no.

8 Q. Do you feel like you've conducted that type of research  
9 now today?

10 A. Yes, I do.

11 Q. Doctor, in your direct, you showed the jury a chart that  
12 went through various other diseases that could inhibit  
13 someone's impairment, correct?

14 A. I'm not sure which chart.

15 Q. The obesity chart?

16 A. The restrictions?

17 Q. Yes.

18 A. Okay.

19 Q. And I just want to make sure you didn't want to leave the  
20 jury with an impression that there has not been a tremendous  
21 amount of exposure in the United States to workers and  
22 asbestos, correct?

23 A. There's been exposure to workers who have been exposed to  
24 asbestos, absolutely.

25 Q. Doctor, you are familiar with the Surgeon General

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1 reports?

2 A. Which one?

3 Q. The 1985?

4 A. Yes, I am.

5 Q. Doctor, in the beginning of the Surgeon General's  
6 report --, can you see the screen in front of you there?

7 A. Maybe I need it a little bit closer.

8 Q. It details that this report will provide a detailed  
9 review of the relationship between smoking and hazardous  
10 substances in the workplace, and in particular, instructing  
11 because of the added health burden that many workers carry if  
12 they smoke cigarettes.

13 Do you agree with that statement there?

14 A. Well, there certainly is an added health burden of  
15 smoking cigarettes, so I agree with that.

16 Q. And it goes on to say this report will make clear for  
17 some workers this added burden is substantial. Correct?

18 A. Okay.

19 Q. Does it say that?

20 A. Yes, it says that.

21 Q. No better example exists to illustrate this interaction  
22 than that of the asbestos workers.

23 A. That's what it says.

24 Q. Okay. You agree that letter is to the former President

25 Bush that appeared in front of the Surgeon General's report?

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1 A. That's what it says.

2 Q. Doctor, I just want to bring it to your attention just so  
3 we understand some of the magnitude of what we are dealing  
4 with here today.

5 The report says at page 201, the number of workers  
6 exposed to asbestos in the United States has been variously  
7 calculated, but a detailed review by Nicholson and colleagues,  
8 1982, estimated that 18.8 million workers have had more than  
9 two months of exposure in occupations where significant  
10 asbestos exposure are may have occurred.

11 A. It says that.

12 Q. Have you read that statement before?

13 A. I have read that statement before. There are a number of  
14 different numbers that come up, but I wouldn't have any way of  
15 knowing which one was more accurate.

16 Q. Doctor, you wouldn't be here today to suggest that the  
17 Manville Trust is not getting a significant number of people  
18 who have been exposed to asbestos, who have been injured by  
19 asbestos, and do have disease from asbestos, you don't want to  
20 suggest that with your charts yesterday?

21 A. I'm not suggesting that the Manville Trust wouldn't see  
22 people who are diseased from asbestos, no.

23 Q. And you told us yesterday you yourself still see two to  
24 three patients a week as a result of asbestos-related  
25 diseases?

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1 A. I see two to three patients a week for asbestos  
2 surveillance. Not all of them have asbestos-related  
3 diseases.

4 Q. How many a year?

5 A. That would be a hundred to a one hundred and fifty  
6 medical surveillance examinations that I'm doing per year for  
7 asbestos, as well as disability type evaluations. So a number  
8 of them are ill, but not all of them.

9 Q. Doctor, you will agree with me that, unfortunately, a lot  
10 cannot be done today for those people exposed to asbestos,  
11 correct?

12 A. That's correct. Unfortunately.

13 Q. The asbestos fibers stay your lungs?

14 A. Asbestos fibers are not -- not all of them are retained  
15 in the lungs, but there certainly is problematic that a number  
16 of them can be retained in the lungs.

17 Q. There is no way to get them out of your lungs once they  
18 are there?

19 A. Some asbestos fibers are exhaled and are released from  
20 the lungs. Usually that is something that occurs pretty much  
21 right away. Once they been lodged in the lungs, for the most  
22 part, not completely, but for the most part they stay.

23 Q. One of the ways you get it out of your lungs is your  
24 clearance mechanisms are working correctly, right?

25 A. That's one mechanism that they do get out of the lungs

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1 by.

2 Q. Would you agree with me, Doctor, that with people who do  
3 have asbestos fibers lodged in their lungs, the best thing  
4 thick that they can do is quit smoking?

5 A. I always recommend to my patients who are exposed to  
6 asbestos, absolutely, that that they should quit smoking.

7 Q. Even if it's prior exposure to asbestosis, quit today?  
8 A. Any exposure -- all of my patients any way, I tell them  
9 to quit smoking. But my patients who are exposed to asbestos,  
10 I usually discuss with them about quitting smoking, yes.  
11 Q. Even today there is still opportunity for exposure to  
12 asbestos, you will agree with me?  
13 A. Yes.  
14 Q. Are you familiar with Dr. Levin?  
15 A. Yes, I am.  
16 Q. Do you know where Dr. Levin practices?  
17 A. At Mt. Sinai.  
18 Q. You testified a little yesterday talking about some of  
19 the -- we have OSHA and some regulations in place, but Dr.  
20 Levin -- I will give you the title. Medical Examination for  
21 Asbestos-related Disease -- put out in July 1999, published in  
22 this year 2000 -- last year now.

23 There are millions of workers whose exposure to  
24 asbestos dust prior to the implementation of asbestos,  
25 regulation and improved control measures places them at risk

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1 of asbestos-related disease today.  
2 We just touched on that, didn't we?  
3 A. Yes.  
4 Q. In addition, workers are still being exposed to  
5 significant amounts of asbestos when asbestos materials in  
6 place are disturbed during renovation, repair, or demolition.  
7 Given the continued presence of asbestos-containing  
8 materials in industrial, commercial and residential settings  
9 throughout the U.S., a sizable population remains at risk of  
10 asbestos-related disease.

11 Do you agree with that, Doctor?  
12 A. I agree. I think the population is decreasing over time,  
13 but there is still considerable opportunity to be exposed to  
14 asbestos.

15 Q. Doctor, will you agree with me that 70 to 80 percent and  
16 sometimes up as high as 90 percent of asbestos workers are  
17 smokers?

18 A. That was a big range that you gave me. I think 70 to 90  
19 percent and --

20 Q. There has been different ranges, 80 to 90 percent  
21 usually --

22 A. More typically I would see numbers around 80 percent in  
23 some of the insulation studies. I don't know what type of  
24 rate would be outside of those kind of heavily exposed  
25 insulators.

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1 So, for example, the Manville Trust has a very  
2 different population. I wouldn't really know the smoking rate  
3 in that group of people.

4 Q. Are you aware that a trustee testified here today that 80  
5 to 90 percent of the Manville claimants also are smokers?

6 A. I'm not aware of that, no.

7 Q. Do you have any reason to disagree with that?

8 A. I have no reason to agree or disagree.

9 Q. Okay.

10 Doctor, yesterday you talked a little bit about  
11 latency, you require 15 years. You will agree with me that  
12 there's literature showing disease at less than fifteen years?

13 A. There's literature showing disease at less than fifteen  
14 years in a very heavy exposed population. So not in a  
15 population that we would see today, but in a population of

16 workers that you would have seen many years ago, yes.

17 Q. Would you have any disagreement with Dr. Burns, who  
18 testified earlier in this trial and said that a 10-year  
19 latency period was reasonable for the Trust to use?

20 A. I wouldn't recommend utilizing a 10-year latency period,  
21 not for today's workers, especially for proceeding into the  
22 future, because workers right now are exposed to much lower  
23 amounts of asbestos, and if you're going to use a latency  
24 period like ten years, you're going to be picking up -- you're  
25 going to call something asbestos-related disease that may not

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1 be asbestos-related disease.

2 I have less concern about that 10-year latency period  
3 in the past with a very heavily exposed population. My  
4 findings with the Trust were that it wasn't that kind of heavy  
5 insulator type of exposure, so I'm a little hesitant to use a  
6 ten-year period.

7 Q. Did you see any latency problems at all in any of the  
8 files that you reviewed?

9 A. I didn't really have an issue with the latency period.  
10 Actually, most much them were fifteen years or greater  
11 typically that I reviewed. My concern would be more for  
12 future claims than what I have reviewed.

13 Q. I want to spend time on what you came here to discussion  
14 about the ATS compared to the TDP and get some of your views  
15 on that.

16 A. Okay.

17 Q. Doctor, I think you reviewed documents on both the ATS  
18 and the TDP to go over criteria, correct?

19 A. That's correct.

20 Q. Would you agree with me that the TDP criteria is designed  
21 to pay claims of asbestos-diseased persons?

22 A. That's my understanding. It's supposed to pay for  
23 asbestos-related disease, yes.

24 Q. That says payment of claims. The ATS is a statement  
25 devised to be used by physicians in a clinical diagnosis of

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1 asbestos-related disease; correct?

2 A. ATS is for the purpose of physicians to diagnose disease,  
3 yes.

4 Q. There's a similarity but a little difference in the  
5 criteria there, correct?

6 A. Well, I don't know that I can comment on the TDP criteria  
7 as if it were -- if the purpose of it were diagnosing  
8 disease. I don't see why that would differ from ATS  
9 criteria.

10 Q. You'll agree with me the criteria is designed to pay the  
11 claims of asbestos-diseased persons, correct?

12 A. By diagnosing disease is what you have mentioned.

13 Q. Injured by asbestos?

14 A. Well, insofar as if the TDP criteria is to make payments  
15 for diagnosis of disease for people who have become sick from  
16 asbestos, then it would make sense for it to use guidelines  
17 that a physician would use for diagnosis.

18 Q. Can you be injured from asbestos and still not have a  
19 clinical diagnosis, Doctor?

20 A. You can have pathology -- you can have changes in your  
21 lungs. You can have fibrosis that is occurring and you're not  
22 sick from it yet, yes.

23 Q. You can be injured and yet not clinically diagnosed?

24 A. You can have lung fibrosis, that type of thing, I guess

25 it depends on what injury means, but not clinical illness.

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1 Q. And you are aware that the TDP is paying for a person  
2 injured or damaged by their exposure to asbestos?

3 A. I'm not really aware of the TDP in terms of what they  
4 have spent is, but I thought it was to pay for someone who was  
5 clinically diseased, that's what I thought it should be --

6 Q. Doctor, you spent a lot of time going through a lot of  
7 TDP documents?

8 A. Yes, I have.

9 Q. And it's your belief that the Trust shouldn't pay anyone  
10 unless they have a clinically-diagnosed disease?

11 A. I wouldn't say who the Trust should and shouldn't pay  
12 for. It would make sense to me as a physician if I had  
13 limited funds to pay people who are sick, who have a disease  
14 process and are ill, as opposed to paying for changes in a  
15 chest x-ray that may or may not affect the individual.

16 Q. But you don't know --

17 A. I can't tell you what they were thinking in terms of  
18 payment.

19 Q. You can't tell me for compensation purposes whether the  
20 injuries here account for damage to a person versus -- even  
21 though they don't have a clinical diagnosis?

22 A. I mean, as a clinician, that's what I'm looking for. I'm  
23 looking to see whether lung, you know, x-ray findings,  
24 pulmonary function findings, whether the process of fibrosis  
25 eventually leads to impairment. So I would really be looking

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1 at the impairment part.

2 Q. You're not here to tell us about compensation, who should  
3 be compensated, who should not be?

4 A. No.

5 Q. How you value people who are injured by asbestos?

6 A. That's not my role.

7 Q. You went on little bit yesterday about the scarring  
8 process of asbestosis, scars in lungs, causes of fibrosis?

9 A. Yes.

10 Q. Again, that's occurring during this period of time,  
11 correct?

12 A. Well, it begins to occur during that period of time.

13 Q. You have the exposure and, as we established, 80, 90  
14 percent of people smoking during the exposure, the latency  
15 period, the fibrosis occurring there.

16 Doctor, asbestosis is a progressive disease?

17 A. Well, the initial part of your statement I don't know if  
18 I'm answering that as to the smoke rate, that I can't comment  
19 on. The question that you -- the latter question in terms of  
20 asbestosis being a progressive disease, yes, it tends to be a  
21 progressive disease. It is not reversible.

22 Q. As you get here, it just keeps getting worse, can cause  
23 death, but sometimes just causes --

24 A. It doesn't always continue to progress either. That's  
25 something that is difficult to determine who will progress and

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1 who won't, but it certainly doesn't improve.

2 Q. Doctor, we have spent a lot of time on talking about  
3 restrictive disease. We're going to talk about that, but I  
4 just wanted to touch on the ATS criteria on that.

5 Doctor, will you agree with me that the ATS in their  
6 clinical findings talks about the restrictive nature of the



7 disease in an advanced stage?  
8 A. They say in advanced stages, asbestosis is a restrictive  
9 lung disease associated with, and they go on to discuss all of  
10 the different symptoms.  
11 Q. You have to be pretty down on that chart, clinical  
12 stages, and even advanced clinical, to start the restrictive  
13 patterns; is that correct?  
14 A. No, I wouldn't say that they are talking about advanced  
15 stages, they are talking about the dyspnea that occurs, the  
16 clubbing of the fingers. Clubbing of the fingers occurs when  
17 someone doesn't get enough oxygen to their system.  
18 In other words, to get curving of the fingernails,  
19 that is a very advanced stage of the disease. I don't think  
20 they are saying the restrictive part of is advanced.  
21 You may have a mild restrictive defect. I think the  
22 advance part is all of the other symptoms they are listing to  
23 go along with that.  
24 Q. Doctor, it says in advanced stages asbestosis is a  
25 restrictive lung disease?

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1 A. Associated with dyspnea, clubbing of the fingers, basilar  
2 crackles and widespread irregular opacifications on chest  
3 x-ray. So I think the statement is all inclusive.  
4 Q. In advanced stages, one has restrictive shortness of  
5 breath, clubbing of the fingers, the crackles, and then the  
6 opacifications, and you refer to the advance stages when you  
7 get --  
8 A. Even beyond the initial clinical, certainly.  
9 Q. Okay.  
10 Doctor, you are of the opinion that asbestos-related  
11 diseases are dose response, have a dose response?  
12 A. Asbestos-related diseases have a dose response  
13 relationship to asbestos exposure.  
14 Q. That means the more asbestos you get in your lungs the  
15 more likely you will get disease?  
16 A. Yes.  
17 Q. Doctor, I'd like to talk a little bit about the  
18 comparison of the ATS and the TDP. Doctor, are you a member  
19 of the ATS?  
20 A. No, I am not.  
21 Q. So the jury has a clear understanding of what the ATS  
22 standard is, can you tell us a little bit about that.  
23 A. The American Thoracic Society. It would be one of the  
24 kind of societies that pulmonologists, for example, belong to.  
25 Q. And there are other criteria one can use for diagnosing

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1 asbestos-related diseases?  
2 A. There are other criteria, but I don't see that as  
3 probably the most accepted criteria, yes.  
4 Q. Doctor, you will agree with me in the ATS -- this is in  
5 the summary section, the end of the four, five page document  
6 going through everything about the asbestos disease and  
7 clinical process -- they come to a summary on exactly what we  
8 should do.  
9 They say in the absence of pathological examinations  
10 of the lung and the tissue -- that would mean actually  
11 examining the tissue for fibers?  
12 A. Yes. That would mean either autopsy or biopsy of lung  
13 tissue.  
14 Q. Would you recommend the Trust to do that in order to make  
15 sure their claimant had asbestosis, to get lung biopsy?

16 A. That would be very invasive. I would absolutely not  
17 recommend for the Trust to do that.

18 Q. All right. The diagnosis of asbestosis is a judgment  
19 based on a careful consideration of all relevant clinical  
20 findings.

21 You will agree with that?

22 A. Yes, I do.

23 Q. They list two necessary items, correct?

24 A. That's correct.

25 Q. They talk about a history of exposure?

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1 A. Yes.

2 Q. And that would go to the top, we go back and find out the  
3 initial exposures. Then they go, an appropriate time interval  
4 between exposure and detection.

5 Is that what we call the latency period?

6 A. That's the latency period. And the text recommended  
7 latency's fifteen years.

8 Q. That's what they would be, the two necessary findings are  
9 exposure -- one there, it's a necessary finding. Then they  
10 have to have the latency, correct?

11 A. That is correct. Those things in and of themselves  
12 wouldn't make a diagnosis, but they would be the first two  
13 requirements, not the only actual, absolute requirements.

14 Q. Before you could ever diagnosis someone with asbestosis,  
15 you have to make sure they are exposed to asbestos?

16 A. Exactly.

17 Q. You testified an actual cause of asbestosis is --

18 A. Asbestos.

19 Q. It's named after that. Okay. Then you have the latency  
20 period because it needs to scar the lungs and turn it into  
21 fibrosis process?

22 A. It does take time for that process to occur.

23 Q. Then, Doctor, we have the following clinical criteria is  
24 a recognized value, correct?

25 A. That's correct.

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1 Q. And these are some of the things you talked about  
2 yesterday. You will agree with me, not all of them are  
3 required?

4 A. It does not say that -- it does not require that each of  
5 those things be present.

6 Q. The ATS even states, you could have disease without  
7 having any of these?

8 A. You just have to show me where it states that.

9 Q. I'm not sure if you showed this to the jury yesterday. I  
10 am going to show them what the document is that we are talking  
11 about here. It is The Diagnoses of Nonmalignant Diseases  
12 Related to Asbestos.

13 We call it non-malignant because it's not a cancer;  
14 is that correct?

15 A. Yes.

16 THE COURT: Has that been marked or offered in some  
17 way.

18 MS. KEARSE: I will mark that, your Honor, as N2.

19 Q. The official statement of the American Thoracic Society  
20 was adopted by the ATS board of directors on March 1986.

21 Okay?

22 A. Okay.

23 Q. I will show you the section we were reading from.

24 THE COURT: This is the summary at the end?

25 MS. KEARSE: Of the ATS document, your Honor.

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1 THE COURT: Yes.

2 Q. This document has focused on clinically detectable  
3 interstitial fibrosis due to asbestos -- an interstitial is  
4 fibrosis, when we talked about the bilateral interstitial  
5 disease?

6 A. That refers to that scarring process that occurs with  
7 asbestosis.

8 Q. Okay. The interstitial disease?

9 A. That's how the Trust seems to refer to asbestosis.

10 Q. Interstitial fibrosis due to asbestos exposure. While  
11 direct examination of lung tissue is the most reliable method  
12 of diagnosis, as stated above, this is rarely indicated in the  
13 assessment of workers for compensation purposes. Open lung  
14 biopsy is indicated in our opinion only when a clear health,  
15 rather than a financial, benefit is likely to be provided.

16 In the absence of pathologic examination of lung  
17 tissue, the diagnosis of asbestosis is a judgment based on a  
18 careful consideration of all relevant clinical findings.

19 We just talked about those findings right there.

20 A. Yes.

21 Q. Of these, the findings on the chest --

22 A. You can say X-ray.

23 Q. X-ray?

24 A. Roentgenogram.

25 Q. -- are the most important. When this criteria is not

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1 met, considerable caution is warranted. The specificity of  
2 the above criteria increases with increasing numbers of  
3 positive criteria.

4 Would you agree with me, the more positive criteria  
5 in the recognized value the more sure you are that you have  
6 asbestosis?

7 A. Yes.

8 Q. As in all clinical judgments, confounding variables, such  
9 as the presence of other clinical conditions that affect these  
10 criteria, should be evaluated. Correct?

11 A. That I agree with.

12 Q. It is possible that interstitial fibrosis may be present  
13 even though none of these criteria are established, but in our  
14 opinion, in these circumstances, the clinical diagnosis cannot  
15 be made.

16 Correct?

17 A. Yes. What that is saying is that interstitial fibrosis,  
18 the scarring, may exist, but it is impossible to diagnose it.

19 Q. Right. You could still have disease?

20 A. I wouldn't call it disease at that point. I would say --

21 Q. You may have interstitial fibrosis?

22 A. You can have the fibrotic process occurring, but in my  
23 opinion it is not yet clinical disease.

24 Q. Doctor, we're going to be talking about some of  
25 these -- you're aware of some of the authors of the ATS?

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1 A. Yes.

2 Q. Do you know any of these people?

3 A. I have heard some of the names. I don't personally know  
4 any of those people.

5 (Continued next page)

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1 EXAMINATION CONTINUES

2 BY MS. KEARSE:

3 Q. Doctor, do you follow the ATS's suggestion, clinical  
4 diagnosis, in the usual clinical setting the diagnosis of  
5 asbestosis has to be made in the absence of -- lung  
6 examination, we just talked about that. The benefit of doubt  
7 should be given whenever the clinical features and  
8 occupational exposure data are compatible with the diagnosis.

9 A. I have mixed feelings about that one. As a physician,  
10 when somebody -- when I am not certain that somebody has  
11 clinical disease, I hate to give them a disease. Because I  
12 think it has psychological effects, can actually be adverse  
13 and can make the person feel even sicker. So that part of it  
14 is a difficult thing to do.

15 On the other hand, for compensation purposes, if the  
16 person will somehow get a Workers Compensation benefit or  
17 something like that, I certainly want to make sure that if  
18 somebody is -- does have a disease process that I feel is  
19 related to asbestos, that I report it accordingly.

20 Q. Thank you.

21 ATS recognizes that when many or all of these  
22 features are present the diagnosis is made without  
23 difficulty. You will agree with that?

24 A. That's correct.

25 Q. The history, latency, and all four of those you could

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1 check off, it's -- you are sure beyond a reasonable doubt,  
2 that there is disease there?

3 A. I would have to see each circumstance, but then it  
4 becomes clear.

5 Q. However, in the absence of doing the lung tissue, the  
6 diagnosis is always inferential, correct?

7 A. It's an inferential process but can become -- it can  
8 become very clear with appropriate clinical skills and  
9 laboratory evaluation.

10 Q. Doctor, part of that is saying, you may -- you may find  
11 one person has disease and someone goes to another doctor and  
12 they may not have disease or vice-versa, you may not find it  
13 and they may go find it, and fine disease?

14 A. I think that typically you are going to find some level  
15 of consistency among doctors. Certainly when the -- when

16 asbestosis, when it is clearly clinical disease, and when it's  
17 severe, actually when it's clearly severe clinical disease.  
18 If you have minimal asbestosis you might find some doctors  
19 will vary on their diagnosis.

20 Q. Doctor, did you disagree with the doctor's notes that  
21 were in the files?

22 A. For the most part when I had clinician's notes that were  
23 in the files, the one who actually evaluated the patient and  
24 diagnosed asbestosis, not always but for the most part I  
25 agreed with those. The problem is there weren't a tremendous

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1 number of them. I don't know that I agreed all of the time.

2 Q. Your testimony is when there is --

3 MR. SCHROEDER: Excuse me.

4 THE COURT: Allow the witness to finish.

5 A. I can't tell you that I agreed every single time a  
6 clinician did conduct a history and physical and then made a  
7 diagnosis that I agreed with it, but I -- certainly I lend  
8 tremendous credence to that when I was reviewing the files.

9 THE COURT: The witness, if she will just answer the  
10 question succinctly --

11 THE WITNESS: Okay.

12 THE COURT: -- we will move things better.

13 Q. Doctor, would that include if a doctor diagnosed someone  
14 with asbestosis in a BID, a non-disabling BID and diagnosed  
15 him as asbestosis, is it your testimony that you agreed with  
16 their diagnosis, that they had asbestosis?

17 A. When I reviewed the claims files, I don't think that any  
18 of the ones that were non-disabling that I actually made a  
19 diagnosis of asbestosis. Typically, either it didn't appear  
20 to be asbestosis or there just wasn't enough information.

21 Q. You are --

22 A. Most of them also did not include clinical information.

23 Q. Doctor, that was in your opinion?

24 A. In my opinion, yes.

25 Q. Even when there was a doctor's letter in there, stating

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1 they did have asbestosis, a non-disabling asbestosis?

2 A. It was very infrequent that there was a doctor's letter  
3 other than a radiologist.

4 Q. We are going to get to some of the claims a little bit.

5 Doctor, yesterday one of your main, I think,  
6 disagreements with the Trust criteria is one slash zero  
7 criteria, is that correct?

8 A. Well, utilizing a one slash O without other information,  
9 yes.

10 Q. A one slash zero, again for the jury, is looking at the  
11 X-rays, where a B-reader would compare one X-ray to a standard  
12 ILO, standard International Labor Organization standard, they  
13 compare X-rays?

14 A. That's correct.

15 Q. Okay. And they see whether or not there is disease on it  
16 and one --

17 A. They see whether or not there is fibrosis on it.

18 Q. Okay. One slash zero means a B-reader reviewing the film  
19 saw fibrosis; is that correct?

20 A. They reported it as slight fibrosis with the possibility,  
21 with severe -- with consideration. Serious consideration I  
22 think is how it is phrased, that there is -- a normal film.

23 Q. Doctor, you will agree with me that the ATS does not  
24 require a one slash one?

25 A. ATS, basically, the way it is stated, it is not up there

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1 anymore, is that they lend credence or something to that  
2 effect.

3 Q. They talk about a one slash one being of a recognized  
4 value?

5 A. That's correct.

6 Q. Under the ATS it is not a requirement to have a one slash  
7 one?

8 A. No, it is not.

9 Q. It is a recognized value, you have a one slash one, you  
10 are saying B-reader one sees one, and he assumes the next  
11 person will see it, right?

12 A. I'm sorry. Say that again.

13 Q. A one slash one would mean the B-reader who is reading  
14 the X-ray sees a profusion level of one and grades it as  
15 another one because he thinks the other reader will see it as  
16 a one, is that correct?

17 A. Not exactly. I think the way ILO says is that he reads  
18 it as that it has some slight changes and that's what  
19 he -- didn't give serious consideration to other -- to other  
20 possibilities, that that's what he thought it was.

21 Q. Doctor, I think you were shown a document yesterday that  
22 said the only reason the Trust is usually one slash zero is to  
23 settle claims.

24 A. I don't recall.

25 Q. Do you remember seeing that?

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1 A. I don't recall saying they are using it just to  
2 settle -- for the purpose of settling claims. But utilizing  
3 one slash zero is not something I would recommend without  
4 other clinical information.

5 Q. Okay. With other clinical information, is there anything  
6 wrong with a one slash zero?

7 A. There are sometimes with a one slash zero, if I have all  
8 of the other important clinical information, that I can make a  
9 diagnosis of asbestos related disease but I would need to have  
10 pretty convincing evidence otherwise.

11 Q. Doctor, I would like to talk a little bit about the one  
12 slash zero. Again, you are not a B-reader. You send your  
13 X-rays to a B-reader to have read?

14 A. Yes, I do.

15 Q. Okay. If someone does come to you with a one slash zero,  
16 have you diagnosed patients with asbestosis?

17 A. I have on rare occasions, yes.

18 Q. But you agree with me that there are prominent members of  
19 the profession that agree that a one slash zero means  
20 asbestosis?

21 A. I think everyone agrees that a one slash zero means that  
22 there is fibrosis, that the reader meant it to read as that  
23 slight fibrosis with serious consideration that there was  
24 a -- there was not any evidence of fibrosis, they would take  
25 it for what it is.

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1 Q. You didn't want to leave the impression with the jury  
2 that the TDP's acceptance of a one slash zero is unreasonable,  
3 is it?

4 A. I think that real issue I have is that there wasn't the  
5 requirement for other clinical information as well, that the  
6 chest X-rays stood alone to make a diagnosis.

7 Q. You will agree with me that chest X-ray is one of the  
8 most important things in the ATS?  
9 A. Yes.  
10 Q. You have the most -- you have the necessary history,  
11 latency and the X-ray, correct?  
12 A. Those would be the two -- the two are absolute criteria  
13 and the chest X-ray would be one of the most important things,  
14 yes.  
15 Q. Doctor, would you agree with me in your review of the  
16 medical literature that there is an abundance of literature  
17 out there that shows the profusion levels of one slash zero or  
18 greater have shown fibrosis and opacities in the lungs?  
19 Are you familiar with some of these studies?  
20 A. I am familiar with some of these studies. There  
21 certainly is literature out there that shows levels of one  
22 zero, in correlating the process, has fibrosis of the lungs.  
23 There also -- the correlation isn't real strong. It becomes  
24 much stronger as the levels of profusion increase.  
25 Q. You will agree with me even in -- into 1983, the ILO

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1 there in Geneva, who is responsible for the 1980 ILO readings,  
2 correct?  
3 A. I see.  
4 Q. Established it. That they state that diagnosis of  
5 asbestosis depends upon, one of the things is the radiological  
6 features consistent with basal fibrosis and they call it  
7 category one slash zero and over. ILO 80.  
8 A. That's what that says on the slide.  
9 Q. Okay. Again, in 1987, Bohlig, pulmonary fibrosis, small  
10 opacities of profusion one slash zero or more.  
11 A. Again, that's what that says there.  
12 Q. The next one, please.  
13 Do you have any reason to disagree with others in the  
14 field using the one slash zero to either study disease in the  
15 field for asbestos workers that have disease as the one slash  
16 zero?  
17 A. Very frequently, for the purpose of research, a cutoff of  
18 one slash zero is utilized. That's not necessarily the  
19 recommendation of even those researchers in terms of clinical  
20 diagnosis. So there is a little bit of a difference between  
21 what research may use and what is utilized for clinical  
22 diagnosis.  
23 Q. Doctor, will you agree with me when they are doing these  
24 research studies for disease at a one slash zero, they are  
25 looking for disease, correct?

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1 A. What they are actually -- they are actually not looking  
2 for disease because they are only looking at chest X-rays.  
3 What they are looking is for chest X-ray findings of  
4 fibrosis.  
5 Q. And that relates to the population who has been exposed  
6 to asbestos and seeing what the changes are occurring from  
7 exposure to clinical diagnosis and they recognize a one slash  
8 zero to be of value in evaluating these people?  
9 A. For research purposes, they are using a one slash zero to  
10 indicate the beginning levels of fibrosis.  
11 Q. They would do that because, obviously, that has some  
12 concern over an -- in a worker having a one slash zero  
13 reading, correct?  
14 A. I don't know that you could extrapolate that from those  
15 studies.

16 Q. This doctor -- you agree with me, they are studying  
17 populations of asbestos exposed workers?  
18 A. That's exactly right, looking at population based studies  
19 and utilizing a one slash zero for that purpose.  
20 Q. They are finding abnormalities, let's go to Barnhart,  
21 1988. The findings in our evaluation predominant ILO one  
22 slash zero profusion abnormalities is consistent with those of  
23 other standards.  
24 They are saying there is abnormality in the lung at a  
25 one slash zero, correct?

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1 A. That's what that says right there.  
2 THE COURT: Is this already in evidence?  
3 MS. KEARSE: Yes. I am going to mark these.  
4 MR. SCHROEDER: I would object to the slide. Those  
5 are snippets from studies. I think the -- what we are doing  
6 is if they have studies and they want to show the studies, at  
7 least I would like the relevant portions that --  
8 THE COURT: We will put them in. You can move to  
9 strike if the studies are not made available.  
10 MR. SCHROEDER: All right.  
11 MS. KEARSE: I have all the studies. We will provide  
12 a list at the end of the testimony with those.  
13 Q. Doctor, the ILO is the organization that we talk about  
14 doing the one slash one and one slash zero's?  
15 A. Yes.  
16 Q. Okay. I want to show -- we will mark this as M-3. The  
17 Encyclopedia of Occupational Health and Safety. If we can  
18 read it. By International Labor Office in Geneva. It is  
19 dated 1983. Three years after they put the standards out for  
20 the ILO's.  
21 Doctor, have you seen this document before?  
22 A. This is coming out of the 1983 textbook? There is a much  
23 more recent one, but okay.  
24 Q. Will you agree with me in the asbestosis section we have  
25 a summary of diagnosis?

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1 A. I agree that there is a summary of diagnosis there.  
2 Q. Okay. And the diagnosis of asbestosis therefore depends  
3 on a history of significant exposure to asbestos dust rarely  
4 starting less than ten years.  
5 They say, you know, ten years you may have  
6 something. It's rarely before ten years but they -- they use  
7 a ten-year latency there, correct?  
8 A. That's what the old textbook utilizes. I am not even  
9 sure what the current one would utilize.  
10 Q. The one I have is the '83 one. We can compare that.  
11 This is the one I have.  
12 Okay. B, the radiological features consistent with  
13 basal fibrosis of a one slash zero and over, ILO 1980.  
14 A. That's what it says there.  
15 Q. Doctor, do you know Doctor Weill?  
16 A. I know the name and some of his research.  
17 Q. Do you recall seeing his name on the list of authors of  
18 the ATS?  
19 A. Yes.  
20 Q. The jury may have seen this before. Doctor Weill  
21 made -- he wrote, the diagnosis of asbestos related disease a  
22 year after the standards went out in '86. This is 1987.  
23 He states, for one reader this benefit will be more  
24 or less equivalent to and ILO reading of one slash one for



25 irregular small opacities.

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1 When we talk about the opacities, are we talking  
2 about the fibrosis?

3 A. Yes.

4 Q. Process? Okay.

5 I am not sure, can you explain what opacities are?  
6 Can you spend a second just to explain what the opacities are?

7 A. Sure.

8 Opacities is what you would see on the chest X-ray.  
9 What they reflect is actually the fibrosis that occurs, the  
10 scarring that occurs shows up on an X-ray as small opacities.  
11 They tend to be irregular with asbestos exposure.

12 Q. One way you tell about the asbestos exposure is that they  
13 are irregular versus some other exposures, the opacities would  
14 be round?

15 A. That is correct.

16 Q. Doctor, would you agree Hans Weill stated that it's  
17 unfortunate that some readers have interpreted the ATS, with  
18 everybody talking about, to suggest that a reading of at least  
19 a one slash one for small opacities is required to support a  
20 diagnosis of asbestosis?

21 Correct?

22 A. That's what it says, yes.

23 Q. Do you agree with Mr. Weill -- Doctor Weill?

24 A. I agree that you should not exclude somebody who has a  
25 film level one zero if they have other evidence of

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1 asbestosis.

2 Q. Did you find in any of your reviews of the claim files,  
3 did you find any one of the one slash zero to have asbestosis?

4 A. No, I did not. They didn't have other sufficient  
5 evidence of disease.

6 Q. Would you have any reason to disagree with Doctor  
7 Selikoff also finding that the lowest positive reading could  
8 be a one slash zero?

9 A. Again, a one slash zero is exactly how it is defined. It  
10 is read as slight fibrosis with serious consideration that  
11 non-exists.

12 Q. So you agree with me then we could have a one slash zero  
13 and you want more information on that before you would  
14 diagnosis someone with asbestosis, correct?

15 A. Yes.

16 Q. All right. You also had some other criteria that dealt  
17 with the shortness of breath. We talked about the crackles  
18 and the rales, correct?

19 A. That's correct.

20 Q. Do you require everyone to have crackles and rales?

21 A. No.

22 Q. I probably sound like I have a lot of rales in my throat  
23 here, but the crackles, you will listen to them and they sound  
24 like cellophane when you are listening to them?

25 A. Yes.

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1 Q. Okay. How many of your patients that you have diagnosed  
2 with asbestos related diseases have crackles and the rales?

3 A. Probably just under 50 percent.

4 Q. You would agree with me that you could have asbestosis or  
5 asbestos related disease without the crackles and without the  
6 rales?

7 A. Yes.  
8 Q. And without the clubbing?  
9 A. Yes.  
10 Q. They may be far more advanced stages where you'd see some  
11 of those?  
12 A. Yes.  
13 Q. Doctor, pleural plaques, where on this would you find  
14 pleural plaques?  
15 Would that be a clinical diagnosis?  
16 A. Pleural plaques is -- that's a chest X-ray finding. I  
17 don't say it is a clinical diagnosis of disease, no.  
18 Q. Is it a marker?  
19 A. It's utilized as a marker for asbestos exposure at  
20 times.  
21 Q. If you find a one slash zero with pleural plaques, are  
22 you -- does it give you any more assurance that you have an  
23 asbestos related injury?  
24 A. Well, the pleural plaques is separate from the pleural  
25 fibrosis so it gives you a little more assurance that's

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1 asbestos exposure that may be the result of your one slash  
2 zero. So it helps a little bit. But they are two separate  
3 processes. So it really doesn't aid in the diagnosis of  
4 asbestosis.  
5 Q. It is kind of like a signature? If you have a pleural  
6 plaque and you have a history of exposure and latency, and  
7 you've got pleural plaques in your X-ray with the reading, it  
8 is kind of a signature that it is asbestos related?  
9 A. It is a marker that there has been asbestos exposure.  
10 Q. Did you see in your review of the files claims with  
11 pleural plaques?  
12 A. Yes.  
13 Q. Did you diagnosis any of those with asbestos related  
14 diseases?  
15 A. I would think that some of the chest X-rays that had  
16 pleural plaques eventually ended up with diagnosis of  
17 asbestosis. But it would be based on other things, not the  
18 pleural plaques.  
19 Q. Did you diagnosis anyone with asbestosis if they  
20 had -- if they didn't have impairment?  
21 A. If they did not have impairment? Well, I was really  
22 looking for an impairment. That's the way I would diagnosis  
23 clinical disease.  
24 Q. Is that one of your main criteria, that you look for  
25 yourself, as impairment?

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1 A. Impairment, meaning symptoms, like shortness of breath or  
2 pulmonary function findings.  
3 Q. You will agree with me that's on the recognized value  
4 section of the ATS?  
5 A. That's correct.  
6 Q. Doctor, I want to spend a little bit just about what we  
7 were talking here, about some of the clinical disease  
8 process.  
9 A. Okay.  
10 Q. Are you familiar with the literature that there is  
11 disease and actual asbestosis in this area here?  
12 A. Within that range, I would really call it a -- like a  
13 fibrotic process. I wouldn't really call it disease until it  
14 is diagnosed as clinical disease.  
15 MS. KEARSE: Could I have chart 14, please?

16 Q. Doctor, are you familiar with some of the studies that  
17 have looked at populations of asbestos exposed workers and  
18 have shown that upon reviewing the lungs, a lot of times these  
19 are on autopsy, that there were percentages of normal  
20 findings, so it would be non-clinical yet, and yet there was  
21 disease, and I will start with Doctor Epler, 1978.

22 One out of 458 parents with such disorders chronic  
23 diffuse infiltrative lung diseases histologically -- is that  
24 looking at the lung tissue?

25 A. That's correct.

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1 Q. Okay. Confirmed, forty-four or nine point six percent  
2 had normal prebiopsy films.

3 A. That's what it says.

4 Q. Liddell in 1980 -- do you know who Doctor Liddell is?

5 A. I am familiar with some of his research.

6 Q. He actually was one of the prime people involved in the  
7 ILO in 1980, of actually setting out the twelve point  
8 standards?

9 A. Yes.

10 Q. Okay. He found that parenchymal, which would be lung  
11 changes, had been recorded in 23 of 31 deaths so coded but  
12 five were normal.

13 A. That's what that little piece of information says.

14 Q. Doctor Kipen in 1987, a negative chest radiograph does  
15 not exclude the presence of interstitial fibrosis or  
16 asbestosis in a substantial proportion of insulation workers  
17 who previously were exposed to asbestos who develop lung  
18 cancer.

19 A. Again, that's what it says.

20 Q. You agree with me, doctor, you could have the  
21 injury -- interstitial fibrosis, only diagnosable in a  
22 clinical setting, after you looked at the tissue on autopsy?

23 A. You can have fibrosis on autopsy that has not been  
24 detected by radiology, yes.

25 (Continued on the next page.)

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1 BY MS. KEARSE:

2 Q. And it could actually be a cause of death to have the  
3 fibrosis and asbestosis even though you never had any clinical  
4 symptoms to it?

5 A. Not typically. Typically, if asbestosis is the cause of  
6 death you do have clinical symptoms.

7 Q. Doctor, do you recall reviewing one of the claims where  
8 only on autopsy did you find a reading of asbestosis?

9 A. Say that again.

10 Q. Do you remember reviewing the records of Joseph Slusser?

11 A. I don't really recall the names.

12 Q. You reviewed the files and made notes?

13 A. That looks like some of my scribbles.

14 Q. And for this gentleman do you recall that reviewing the  
15 file of Mr. Slusser?

16 A. I wouldn't really recall his exact file. Those are  
17 certainly my notes. If you want to provide me with the file,  
18 that would help.

19 MS. KEARSE: May I approach, your Honor?

20 THE COURT: Yes.

21 Q. Now, doctor, --

22 THE COURT: Is that being marked separately? Are  
23 you going to mark all these at the end?

24 MS. KEARSE: M 4.

25 Q. Doctor, is this one of the BID claims, that's the

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1 non-disabling claims, and is this typical of your notes, you  
2 got the claims, did you review them at home or in your office?

3 A. I reviewed them at home. At times I just wrote down some  
4 notes.

5 Q. You took notes and we have your notes. For this  
6 gentleman this is the extent of your notes?

7 A. Okay.

8 Q. Okay.

9 And this gentleman would not have met your criteria,  
10 correct?

11 A. Well, this gentleman had a diagnosis by autopsy. I  
12 wouldn't do that. I would conduct a clinical evaluation.  
13 This is not something that I would make a diagnosis on.

14 Q. But in your notes you did not -- you distinguished  
15 everything, whether you were able to diagnose or not diagnose,  
16 it would not have met your clinical diagnosis had you looked  
17 at him, correct?

18 A. The information I have here is just my jottings with  
19 which was an autopsy with interstitial fibrosis with asbestos  
20 bodies. I have no idea in terms of pathology what level that  
21 was. Just based on this information that I have in front of  
22 me, I couldn't make a diagnosis, no.

23 Q. You have the file in front of you?

24 A. This is the file. Okay.

25 Q. Okay. You'll agree, if you'll look, Mr. Slusser had

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1 exposure? Do you see on page six of his claim?

2 A. Page six.

3 Q. The question on the claim form, all the claimants have to  
4 fill out their exposure history?

5 A. Yes.

6 Q. Mr. Slusser says his most significant exposure to  
7 Manville asbestos occurred from 1938 until 1985?

8 A. That's correct.

9 Q. That would give us both exposure and a latency period,  
10 first exposure in 1938, is that correct?

11 A. That's correct.

12 Q. Doctor, we agree that the file indicates that he had  
13 prior pleural plaques?

14 A. If you can point to where that is. I don't see any  
15 medical records of that.

16 Q. I'll agree with you there's no ILO reading in that file.

17 A. Is there a chest x-ray in the file?

18 Q. Right.

19 I'm going to show you what's in the file. February  
20 19, 1996. The letter talks about a review of records and  
21 pathology materials. There was a radiology report of  
22 bilateral pleural plaque formation.

23 I'll go to the second page.

24 These findings support my conclusion, to a reasonable  
25 degree of medical certainty, that Mr. Slusser's occupational

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1 asbestos exposure was the cause of his pulmonary asbestosis  
2 and asbestos-related pleural plaques, and was a substantial  
3 contributing factor to his death.

4 A. This file, if my recollection is correct, was purely  
5 based upon pathology. So I hadn't made a diagnosis nor not  
6 made a diagnosis. It was something where I felt that that

7 wasn't what I would clinically do.  
8 Q. But you'll agree with me it was not until autopsy that  
9 they were able to find that he had asbestosis?  
10 A. As opposed to prior? Well, there's no evidence of having  
11 undergone an evaluation, is there, prior to that?  
12 Q. There's no evidence of having an ILO reading before  
13 that.  
14 A. So I really wouldn't know whether, if he were evaluated  
15 prior to autopsy, I wouldn't know whether he would have been  
16 diagnosed or not.  
17 Q. But he did file a claim for a non-disabling bilateral  
18 interstitial disease; right?  
19 A. I'll agree if that's what you are telling me, sure.  
20 Q. Doctor, I think you testified on direct, you spent a lot  
21 of time talking about impairment. It's your opinion that you  
22 have to have impairment in order to have disease?  
23 A. Yes, that's my opinion.  
24 Q. Have you seen literature where the confounding factors of  
25 smoking and having exposure to asbestos really impair one's

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1 ability to figure out what the impairment is or what the2  
impairment is due to?  
3 A. Would you tell me what literature that you are referring  
4 to?  
5 Q. Okay.  
6 Have you seen such literature discussing the  
7 variabilities of trying to assess someone's impairment when  
8 there are confounding factors of smoking involved?  
9 A. Well, there's some discussion, certainly even the Surgeon  
10 General's report discussed impairment from smoking versus  
11 asbestos, for example, and trying to differentiate the two.  
12 For the most part they concluded that they were  
13 pretty much independent, that they had independent changes.  
14 There may be times in very rare instances where it can be  
15 difficult.  
16 Q. Will you agree with me that you can have x-ray readings  
17 of fibrosis without any impairment?  
18 A. Yes.  
19 Q. So one of the clinical things you can have here is you  
20 can have an x-ray reading of 1/0, 1/1, 1/2 and have disease  
21 process and yet not have impairment?  
22 A. As you are getting up to 1/2 you are very likely to have  
23 impairments. Certainly at the lower levels, yes.  
24 Q. You could have a lower level and have the process  
25 occurring of asbestosis or interstitial disease and not have

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1 impairment?  
2 A. Yes.  
3 Q. But you required impairment in all your reviews of the  
4 files?  
5 A. Yes, I did.  
6 Q. So you would agree then with Dr. Levin, again, at Mount  
7 Sinai, you might not agree with everything he is says, but he  
8 says some patterns with marked parenchymal abnormalities on  
9 x-ray may have no symptoms and have normal pulmonary-function?  
10 A. Yes.  
11 Q. Do you require impairment in everyone who comes to your  
12 office before you will diagnose them with an asbestos-related  
13 disease?  
14 A. Everyone, that's strong. For the most part, I would  
15 require impairment.

16 Q. And you just told me with all the claims that you  
17 reviewed you actually looked for impairment there?  
18 A. I looked for impairment. That's not to say if I had a  
19 chest x-ray of 3/3, or strong evidence, that the impairment  
20 might not be necessary. But very typically I require  
21 impairment.  
22 Q. But you could have a lower level profusion. 1/0 or 1/1  
23 but without the impairment yet?  
24 A. Yes, you can.

25 Q. So you can have a clinical diagnosis and it would be

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1 reasonable for the Trust to accept that claim as a disease?  
2 A. I wouldn't call that a clinical diagnosis, just based on  
3 a chest x-ray.  
4 Q. You just said you could have the disease without the  
5 impairment, correct?  
6 MR. SCHROEDER: Objection.  
7 A. I thought what I said was you can have --  
8 THE COURT: Excuse me.  
9 Ask another question.

10 Q. Doctor, we've talked about the total lung capacities and  
11 you just mentioned the Surgeon General report would you agree  
12 with me --

13 THE COURT: This is from what?

14 MR. KEARSE: I'll mark this as M 5. This is a page  
15 -- I'm sorry. M 6.

16 Q. The presence of a lung injury secondary to one agent or  
17 process does not prevent the lung from being injured by a  
18 second agent.

19 So we're talking about being injured from smoking and  
20 also being injured by asbestos?

21 A. Two separate injuries, sure.

22 Q. In evaluating impairment in an asbestos-exposed smoker,  
23 it may be difficult to apportion the impairment between the  
24 two agents because both cigarette smoking and asbestos  
25 exposure may alter a given lung function test in the same

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1 direction, e.g., both of them will reduce the diffusing  
2 capacity or they may change a test in opposite directions, an  
3 increase in total lung capacity, the TLC, due to smoking may  
4 mask a decline in TLC due to asbestos.

5 I think we talked a little bit that in an obstruction  
6 the TLC will go up and in restriction it goes down?

7 A. That can happen.

8 Q. It's almost cancelling each other out and you're left  
9 with a DLCO?

10 A. Rarely can you not differentiate between the two  
11 situations. I think the Surgeon General's report goes on to  
12 state that typically you can identify it. On some few  
13 occasions it can be difficult.

14 Q. But we have established we've got 80 to 90 percent of our  
15 asbestos workers smoking; right?

16 A. That's correct.

17 Well, actually, I don't know that I ever -- that's  
18 what you have stated to me and it may be the case.

19 Q. Do you have any disagreement with the Surgeon General's  
20 report?

21 A. I don't agree or disagree. I don't know the numbers. I  
22 don't want to report something I don't know.

23 Q. We want to get out of the here. Right. Okay.

24 We mentioned earlier -- this is an article that I

25 have marked M 7, by Dr. Burns. Do you know Dr. Burns?

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1 A. I know his name. I know he's involved with the Surgeon  
2 General report.

3 Q. You know he testified here earlier in this trial?

4 A. Yes. I've been told that.

5 Q. Dr. Burns wrote in his article -- it's called Chest, TLC  
6 In Combined Restrictive and Obstructive Lung Disease.

7 Again, the obstruction can occur from smoking?

8 A. Obstruction, yes, typically occurs from smoking-related  
9 disease.

10 Q. Are you familiar with literature that talks about  
11 asbestos causing obstructive disease?

12 A. Well, there's some literature that shows possibilities of  
13 decline in FEV 1 over FEC ratio. For the most part, the  
14 literature does not show that.

15 Q. There are researchers who have concluded that asbestos  
16 can contribute to obstructive disease?

17 A. I think for the most part the Surgeon General as well as  
18 most researchers indicate that asbestos does not cause  
19 obstructive-related disease although there are a few studies  
20 that indicate that. But those would actually be the  
21 exception, not the rule.

22 Q. Let me tell you what Dr. Burns has to say.

23 He's talking about obstruction and restriction  
24 disease: Because these two processes affect the TLC in  
25 opposite directions, the TLC becomes a poor measure of the

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1 extent of disease and an insensitive measure of the presence  
2 of disease when lung injury is due to the combination of  
3 restrictive-disease process and an obstructive-disease  
4 process.

5 Would you agree with Dr. Burns?

6 A. Again, I agree with it. It rarely occurs. In my  
7 practice, it's very infrequent that I can't tell between a  
8 restrictive and an obstructive process. In the claims files  
9 it was a same thing, very infrequent.

10 Q. Doctor, you would agree with me the ATS addresses the  
11 difficulty sometimes when you have the tobacco-related disease  
12 of the obstructive process, an obstruction?

13 A. It may discuss that in there. The Surgeon General does  
14 as well, but I think the general consensus is that for the  
15 most part you can differentiate between the two disease  
16 processes.

17 Q. Doctor, I want to show you one of the articles that I was  
18 referring to when we talked about asbestos causing  
19 obstruction. Dr. Kilburn, do you know Dr. Kilburn?

20 A. He authored a couple of articles on asbestos that I have  
21 reviewed.

22 Q. And he talked about causing airway obstruction and  
23 asbestosis increases the airway obstruction?

24 A. That's what that one line says. Again, typically, the  
25 literature is showing asbestos not causing an obstructive

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1 process.

2 Q. Do you know a Dr. Rogli (ph.)?

3 A. I'm not certain. Can you give me context?

4 Q. Have you read the Pathology of Asbestos-Related Disease,  
5 Associated Diseases?

6 A. I have not read that text.

7 Q. You are not a pathologist?  
8 A. I'm not a pathologist. That would be a pathology  
9 textbook.  
10 Q. You never heard of Dr. Rogli?  
11 A. I may have heard of him. He's not familiar.  
12 Q. I want to tell you what Dr. Rogli reported in his book on  
13 asbestos.  
14 THE COURT: What's the edition and pages?  
15 MS. KEARSE: This is 1992, Pathology of Asbestos  
16 Associated Diseases, your Honor. I'll mark the page, page  
17 82.  
18 Q. There is also accumulating evidence that exposure to  
19 asbestos and a variety of other mineral dusts can contribute  
20 to chronic obstructive pulmonary disease.  
21 Do you see that?  
22 A. That's what it says.  
23 Q. You disagree with Dr. Rogli?  
24 A. The literature in general points to a restrictive process  
25 as opposed to an obstructive process.

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1 Q. Doctor, quickly, just about a couple of your claims. I  
2 want to review some of the your findings. You reviewed 74  
3 claims out of 300,000 claims, correct?  
4 A. 74 is definitely the number I reviewed.  
5 Q. You didn't have time to review more than 74 claims?  
6 A. I asked for some random sampling of claims files. I was  
7 given 74.  
8 I could have reviewed a few more, not a few thousand.  
9 Q. We're not here to judge the Trust on compensation, of  
10 what they value their claims as?  
11 A. That's correct.  
12 Q. You're here more for a clinical diagnosis from your own  
13 medical review on whether or not you thought, as a physician,  
14 that you could clinically diagnose someone with disease?  
15 A. That's correct.  
16 Q. Doctor, I could show you the things. If you'll take my  
17 word for it, you reviewed 27 BID claims?  
18 A. Okay.  
19 Q. Okay.  
20 And 11 out of 27 of those claims, you had a 1/1 or  
21 greater x-ray profusion?  
22 A. Okay.  
23 Q. And you did not diagnose any of those with  
24 asbestos-related disease?  
25 A. Which means that there was not sufficient other evidence.

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1 Q. I'm going to review one quickly with you, doctor. You  
2 had a Mr. Collins?  
3 A. May I have a copy?  
4 Q. Surely.  
5 Are those your notes from Mr. Collins?  
6 A. Those are my notes.  
7 THE COURT: Are you going to put this whole file in?  
8 MS. KEARSE: Yes, your Honor. I'll mark that as M  
9 8.  
10 Q. Now, these are the extent of the notes I have here. But  
11 a review of the file would show Mr. Collins had an intense  
12 five year, 1942 to 1947, exposure?  
13 A. Well, that would be included in medical information.  
14 That would just be in the proof of claims file.  
15 Q. Did you use any of the information that was in the claim



16 form to help in your diagnosis?  
17 A. I utilized primarily the medical information.  
18 Q. So if someone put information in the claim form itself,  
19 you did not --  
20 A. In terms of their exposure, like I pretty much assumed  
21 that the exposure existed, despite frequently there not being  
22 enough information about it or just information about what job  
23 category. If they said they smoked in it, that type of  
24 information I took. It didn't contain clinical information  
25 like symptoms or that type of thing.

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1 Q. Just quickly, doctor, Mr. Collins' file shows that he had  
2 significant exposure from 1942 to 1947 and he had a latency  
3 period of 42 years. And he had an x-ray.

4 A. All it says --

5 THE COURT: Excuse me. The question has not been  
6 asked.

7 THE WITNESS: I'm sorry.

8 Q. I'll try to review quickly with you. In his file that he  
9 filled out on the claim form or someone filled out for him?

10 A. I'm not sure I agree with that.

11 Q. You don't agree with that?

12 A. If we're looking at the same page, page 6, it says he  
13 worked from 1942 to 1947 in the chemical industry. That's all  
14 the information I have and that it's a circle saying directly  
15 in contact with asbestos. But there's no other information  
16 for me to assess whether the exposure was significant.

17 Q. But he does within his claim form talk about exposure,  
18 correct?

19 A. Yes, for a five-year period it says in the chemical  
20 industry. That's all the information.

21 Q. Okay.

22 In your experience, do you have any experience to  
23 know that there was significant exposures in the chemical  
24 industry for various time periods?

25 A. There may be.

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1 Q. And his x-ray gave him a 1/2?

2 A. That's correct.

3 Q. With pleural plaques, pleural thickening?

4 A. Yes.

5 Q. And a 1/2 gives you more comfort that there's disease?

6 A. A 1/12 would be a significant x-ray finding of fibrosis.

7 Q. There was no obstruction or restriction noted in the  
8 file?

9 A. The only medical information in the file was just a chest  
10 x-ray.

11 Q. Although he had the latency and exposure and a 1/2, and a  
12 1/2 with pleural markers for asbestosis, you felt as a  
13 clinician you couldn't diagnose him with asbestosis?

14 A. There was certainly a latency. He may or may not have  
15 had the exposure. The only information I had was the chest  
16 x-ray. I wouldn't make that diagnosis with just a chest  
17 x-ray.

18 (Continued on next page.)

19  
20  
21  
22  
23  
24

25

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1 THE COURT: You're not saying, as I understand your  
2 answer to this file, that it was unreasonable for the Trust,  
3 based on the information it had, to say that this was a  
4 reasonable diagnosis, are you?

5 THE WITNESS: No. What I'm saying is that I  
6 wouldn't be able to make a diagnosis with just a chest x-ray  
7 reading, as a clinician.

8 THE COURT: I don't understand the relevance of that  
9 to the question before us, the adequacy of these files to make  
10 a judgment with respect to the disease.

11 The Trust, you understand, is not treating. Do you  
12 understand that?

13 THE WITNESS: I understand that.

14 THE COURT: It's paying the claims.

15 THE WITNESS: Yes.

16 THE COURT: My questions have no significance here,  
17 ladies and gentlemen. I'm just trying to clarify the record.  
18 BY MS. KEARSE:

19 Q. Doctor, I was trying to highlight some of the things that  
20 you did see in the claims when you were reviewing them, and I  
21 could go to more, but due to time we are going to move on from  
22 that.

23 A. Okay.

24 Q. Would you agree with me, also, that you did diagnosis  
25 some people that had no x-ray reading and you were able to

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1 diagnose them with asbestosis?

2 A. I don't recall -- perhaps if they had CAT-scans. Did  
3 they have radiology evidence? Typically, I was looking for  
4 radiology evidence. There may have been an example.

5 Q. I'm not going to go through all of them now, but do you  
6 remember Mr. Smith -- my question is, if you had no chest  
7 x-ray and you had someone come in your office with either a  
8 CAT-scan or without a CAT-scan, would you diagnosis anyone  
9 with asbestosis?

10 A. Certainly with CAT-scan I would. Without a chest x-ray,  
11 well, there would be no reason for my office to not obtain a  
12 chest x-ray.

13 Q. What if there was no x-ray in the file, but there was a  
14 doctor's note that talked about that they were diagnosed with  
15 asbestosis but didn't give you a profusion rating, would that  
16 give you comfort to diagnose someone with asbestosis?

17 A. If the x-ray indicated that there was bilateral  
18 interstitial lung disease.

19 Q. It would be a reason for the Trust to pay that claim?

20 A. I would require that it has to be an ILO.

21 Q. Doctor, I want to touch on one more thing, your  
22 statements about smoking does not aggravate asbestosis. You  
23 testified here yesterday -- Tuesday?

24 A. Smoking has not been shown to aggregate asbestosis.

25 Q. In your personal experience, is that upon your review of  
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1 the literature or your personal experience?

2 A. Both.

3 Q. Are you aware of literature that talks about smoking,  
4 assisting in the abnormalities of fibrosis and actually  
5 turning up on the x-ray?

6 A. Smoking has been associated in the literature with

7 increased chest x-ray readings of fibrosis.  
8 Q. And smoking and asbestos combined together, as has been  
9 in the literature, shows more clinical profusion levels on  
10 x-rays?  
11 A. That is not quite as clear in the literature as the prior  
12 question. But there's some literature that shows increased  
13 profusion rate, although that varies. There's other  
14 literature that does not show that.  
15 Q. 15. Doctor, are you familiar with Dr. Selikoff's work?  
16 A. It depends on which part. It's extensive work.  
17 Q. You met Dr. Selikoff?  
18 A. I have, yes.  
19 Q. You testified to that at your deposition. In one of Dr.  
20 Selikoff's earlier studies, 1986, would you agree with me in  
21 his study, he studied a population of asbestos workers and one  
22 of the things they looked at, they found out they had a  
23 smoking history with a majority of the workers?  
24 A. Yes.  
25 Q. You would agree with that?

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1 A. Yes.  
2 Q. And they found that the prevalence of all radiographic  
3 abnormalities, pleural and pulmonary, increased with duration  
4 from onset of asbestos exposure.  
5 That would be our set of exposure here. A positive  
6 smoking history was associated with a significantly higher  
7 prevalence of small irregular opacities indicating  
8 interstitial pulmonary fibrosis.  
9 A. It was associated with the higher prevalence of small  
10 irregular opacities. What the cause of that is though is  
11 really not completely determined.  
12 Q. The mechanism?  
13 A. Right, the mechanism. But certainly there is an increase  
14 of that.  
15 Q. People smoking and exposed to asbestos had more  
16 abnormalities on chest X-rays?  
17 A. Yes, especially at the lower level.  
18 Q. And in 1991, the next one, please. Again they were  
19 looking at the effects of onset of exposure and smoking in  
20 asbestos workers. Blow up the chart, please.  
21 Again, they saw the contribution of cigarette smoking  
22 to prevalence and severity of the interstitial fibrosis is an  
23 additional reason for smoking cessation among asbestos  
24 exposed. They go to a table 5 on that.  
25 Would you agree with me that the cigarettes are

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1 actually contributing to the interstitial fibrosis?  
2 A. Well, the cigarette smoking is contributing to increased  
3 x-ray readings, is really what was concluded from those  
4 studies.  
5 Q. The cigarette smokers were found to have more  
6 interstitial pulmonary fibrosis, correct?  
7 A. They were found to have x-rays read more frequently.  
8 However, it wasn't looked at in terms of a clinical disease  
9 process or other findings. That study was just looking at the  
10 x-rays.  
11 Q. Will you agree with me, Doctor, that there are many  
12 studies that talk about the clearance mechanism being affected  
13 by smoking?  
14 A. There are some animal studies as to that, yes.  
15 Q. And Selikoff continues again, talking about the higher

16 rates of the abnormalities, and talking about the several  
17 recent findings, such an effect of smoking may be due to  
18 interference with pulmonary clearance mechanism and higher  
19 retention of asbestos fibers in the lung. Several recent  
20 experimental studies have converged in demonstrating that  
21 cigarette smoke inhibits asbestos clearance.  
22 A. That's one of the theories that is given for increased  
23 chest x-rays being read with profusion scores.  
24 Q. And a normal lung would have defense mechanisms to clear  
25 some of the asbestos fibers out?

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1 A. A lung would have those kind of defense mechanisms.  
2 Q. And a damaged lung could inhibit the clearance mechanisms  
3 for asbestos fibers?  
4 A. That's theoretical.  
5 Q. And we established that asbestosis is a dose response  
6 disease, so the more asbestos fibers that are kept in your  
7 lungs the more apt you are to get disease?  
8 A. That would be the theory.  
9 THE COURT: Would your bring in to a close. There  
10 has to be a little time for the redirect.  
11 Q. Have you seen internal documents from the industry  
12 showing their knowledge of the defense mechanisms being  
13 attacked by --  
14 THE COURT: Don't answer.  
15 MR. SCHROEDER: Objection.  
16 Q. Dr. I want to finish up with, are you familiar with  
17 former Surgeon General, Dr. Richmond?  
18 A. I know of him.  
19 Q. Have you seen any of his statements to the public that  
20 cigarette smoking significantly increases the lung cancer risk  
21 of asbestos exposure and aggravates asbestosis?  
22 A. I may have seen some of his statements awhile ago.  
23 Q. But you disagree with former Surgeon General Richmond?  
24 A. Well, I'm not sure that that quote is completely in  
25 context. I think it more means that cigarette smoking -- the

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1 lung cancer part of it we're not going to discuss, but it is  
2 more in line with two disease processes compromising the  
3 lungs, thereby aggravating the asbestosis.  
4 Q. And Dr. --  
5 THE COURT: That's enough. Thank you. Any  
6 redirect?  
7 MR. SCHROEDER: Very brief, your Honor.  
8 THE COURT: Yes.  
9 REDIRECT EXAMINATION  
10 BY MR. SCHROEDER:  
11 Q. Dr. Mendelsohn, let me ask you about the Surgeon  
12 General's report real quick since Dr. Burns has testified to  
13 this jury that he wrote this section of the report that deals  
14 with asbestos.  
15 THE COURT: You have on the board now what?  
16 MR. SCHROEDER: Page 259 of the 1985 Surgeon  
17 General's report, your Honor.  
18 Q. Do you see there, Doctor, it the questions raised by the  
19 combination of cigarette smoking and asbestos exposure do not  
20 include whether cigarette smoking is an independent competing  
21 cause of the extensive fibrotic process found in many workers  
22 following prolonged heavy exposure to asbestos.  
23 Cigarette smoking has not been shown to independently  
24 cause this kind of reaction in the lung?

25 A. Yes.

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1 Q. Do you agree with that?

2 A. Yes, I do.

3 Q. Further, on page 239, Dr. Burns writes. Asbestos and  
4 cigarette smoke produce different appearance of injury in the  
5 lung.

6 Do you agree with that?

7 A. Yes.

8 Q. And can you tell us, as a clinician with the appropriate  
9 pulmonary function tests, determine those different patterns  
10 in the lung?

11 A. For the most part, yes.

12 Q. Did the Trust follow those requirements, based on your  
13 review of the claims files?

14 A. No.

15 Q. And, finally, here it says the demonstration -- on page  
16 264, the demonstration of an increased prevalence of  
17 roentgenographic changes interpreted as fibrosis in cigarette  
18 smokers does not establish that the changes are produced by  
19 smoking.

20 As has been discussed earlier, cigarette smokers may  
21 have had a different cumulative asbestos exposure than  
22 nonsmokers in some of the populations studied.

23 Do you agree with that?

24 A. Yes.

25 Q. Finally, Gregg Smith testified in this case: Has there

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1 ever been a definitive study, to your knowledge, that smoking  
2 increases the prevalence of asbestosis? Not that I've ever  
3 seen. Page 22 of his deposition.

4 To your knowledge, is there a definitive study that  
5 smoking increases the prevalence of asbestosis?

6 A. No.

7 Q. Finally, I'm going to show you a request for admission we  
8 sent to the Trust in this case -- sorry, interrogatory number  
9 14.

10 With regard to the contention, contained in paragraph  
11 39 of your complaint, that the effect of cigarette smoking is  
12 so overwhelming that in asbestos workers who smoked any  
13 contribution of asbestos dust exposure to obstructive changes  
14 in the lung functions are negligible. Please state the  
15 factual basis.

16 Answer is. Additionally, plaintiffs state that the  
17 Trust has known from its inception that smoking has a strong  
18 role in causing obstructive changes in lung function.  
19 Plaintiffs also state that they based the allegation contained  
20 in paragraph 39 of the complaint that "the effect of cigarette  
21 smoking is so overwhelming that, in asbestos workers who  
22 smoked, any contribution of asbestos dust exposure to  
23 obstructive changes in the lungs' functions are negligible,  
24 and they pass on that to a passage in a book by Rogley.

25 Do you agree with that statement?

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1 A. Yes, I do.

2 Q. Dr. Mendelsohn, if you apply the appropriate clinical  
3 tests to determine lung function, can you determine those  
4 kinds of obstructive changes and differentiate them from any  
5 restrictive changes that may have been caused by asbestos?

6 A. Yes, for the most part you can.

7 Q. And was there any question asked to you on direct by Miss  
8 Kearse that changes at all your view of how many of the claims  
9 files passed clinical standards for the disease of asbestosis?  
10 A. No.  
11 MR. SCHROEDER: Thank you.  
12 THE COURT: All right. Thank you very much.  
13 Don't leave for a moment.  
14 MS. KEARSE: Thank you, Doctor .  
15 THE COURT: Yes. Thank you from all of us. Ten  
16 o'clock Tuesday, please. Don't discuss the case.  
17 (Jury leaves the courtroom.)  
18 THE COURT: Motions?  
19 MR. BERNICK: I have several items, your Honor.  
20 THE COURT: All right. I don't want to keep the  
21 doctor long. May I see that file, because I'm curious?  
22 MR. BERNICK: Your Honor, I have several things. I  
23 don't mean to keep the doctor on the stand.  
24 THE COURT: I want her.  
25 MR. BERNICK: Sorry.

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1 MR. BERNICK: I'm out of order here. I apologize.  
2 MS. KEARSE: This is another --  
3 THE COURT: The file, please. I'm just curious  
4 about how the Trust operates, since I have had these cases.  
5 This was which file, the -- was this the Collins  
6 file?  
7 MS. KEARSE: Yes.  
8 THE COURT: Collins, the 193?  
9 MS. KEARSE: Yes.  
10 THE COURT: So based on this you would not have  
11 found pleural disease or asbestosis?  
12 THE WITNESS: I wouldn't have made a diagnosis of  
13 asbestosis just based on a chest x-ray. We didn't have any  
14 clinical information about what else may have caused it.  
15 There really wasn't very much exposure.  
16 THE COURT: What about the pleural disease?  
17 THE WITNESS: A pleural plaque is a more consistent  
18 marker so therefore the pleural plaque part of it I wouldn't  
19 really have an issue of it.  
20 I wouldn't call it disease. A pleural plaque may or  
21 may not result in, you know, any kind of symptom in the  
22 individual, but I wouldn't have as much difficulty with that  
23 part of it.  
24 THE COURT: So I take it, though, that under two on  
25 page 6, the worker was directly in contact with asbestos, and

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1 if it was a very substantial amount of asbestos, your view  
2 might have changed?  
3 THE WITNESS: If I had some more clinical  
4 information that it was significant, yes, then I would have  
5 had a different view.  
6 THE COURT: So far as page 6, it's the problem of  
7 just checking without any exposition that you found  
8 troublesome?  
9 THE WITNESS: Exactly. I think the clinical history  
10 could have really clarified it here. I'm not saying that the  
11 person didn't have asbestosis --  
12 THE COURT: I understand the problem. So I take it,  
13 if you were handling a case like this and they asked your  
14 opinion, without seeing the patient, you would have sent it  
15 back and said you want further information on that point?

16 THE WITNESS: Yes.  
17 THE COURT: Anything else you would have asked for?  
18 THE WITNESS: I would have liked to have had the  
19 clinical information, not only the history but if the person  
20 was symptomatic. It would have been helpful.  
21 It's not as crucial, given the level of the chest  
22 x-ray being higher than most, but I would have requested that  
23 clinical information.  
24 THE COURT: And the Roentgenographic interpretation  
25 doesn't cut it?

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1 THE WITNESS: Just by itself, I didn't think it was  
2 enough.  
3 THE COURT: All right. Thank you very much. It was  
4 very interesting. I don't see many of these files. Thank  
5 you.  
6 (Witness excused.)  
7 THE COURT: I hope everything goes well. Next,  
8 please.  
9 MR. WAGNER: Your Honor, can I just hand up a list  
10 of documents that we were going to move admission into  
11 evidence? You will see a red box and some scratched out.  
12 Those are the ones I'm still working through with the  
13 plaintiff, so I will submit a separate list of those.  
14 Everything on that list we are moving for admission  
15 into evidence. There is no objection.  
16 THE COURT: All right. The last number was 79.  
17 This would be Court Exhibit 80.  
18 MR. WAGNER: I will mark all of our copies  
19 accordingly.  
20 THE COURT: Is this being accepted now?  
21 MR. WAGNER: All of those are without objection. I  
22 will make a separate list, the ones that I have drawn a line  
23 through I will make a separate list of those because I'm still  
24 discussing it.  
25 THE COURT: It's not necessary. The court reporter

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1 can list them. He will list everything on Court Exhibit 80 at  
2 this point in the record as admitted.  
3 Court's Exhibit 80:  
4 WS 000449.  
5 SA 300198.  
6 WS 003861.  
7 SA 400192.  
8 WS 002677.  
9 ARF 000939.  
10 ARF 001952.  
11 WS 003967.  
12 DEM 011033.  
13 ARF 001540.  
14 GJ 000004.  
15 GI 000029.  
16 GN 100659.  
17 WS 002379.  
18 GI 100012.  
19 TG 000237.  
20 GI 300139.  
21 GI 300141.  
22 GK 1000939.  
23 GK 300212.  
24 ARF 001485.

25 GJ 000113.

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1 GI 300109.

2 WS 003292.

3 GK 000018.

4 WS 000370.

5 GK 300319.

6 GL 300206.

7 WS 003792.

8 WS 003788.

9 WS 002996.

10 GK 300415.

11 GJ 000113.

12 WS 001490.

13 PX 350734.

14 THE COURT: Next.

15 MS. TEDDER: Your Honor, I'd like to hand the court  
16 back three exhibits which we have previously handed to the  
17 court.

18 Court Exhibit No. 64, which is the Kotin exhibits,  
19 which I think plaintiffs have no objection to. Court Exhibit  
20 69 and 70.

21 Plaintiffs have seen both Court Exhibit 69 and 70,  
22 and there are three documents that I have -- one on the back  
23 of the last page of Court Exhibit 69, two on the last page of  
24 Court Exhibit 70, we are still discussing with the  
25 plaintiffs.

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1 Other than that, they have no objections to any of  
2 the other documents.

3 THE COURT: I'm going to strike it from the list and  
4 you'll have to offer it separately.

5 MS. TEDDER: The three that are at issue?

6 THE COURT: Those three.

7 MS. TEDDER: Certainly.

8 THE COURT: Court Exhibit 64, Court Exhibit 69,  
9 Court Exhibit 70, I am handing to the reporter for adding to  
10 the record at this point all having been admitted.

11 Court Exhibit 64:

12 WZ-001401.

13 WZ-001387.

14 G B-300042.

15 SA-300718.

16 G B 300043.

17 SA-300620.

18 SA-300637.

19 SA 300638.

20 SA-300639.

21 SA-300640.

22 SA-300641.

23 SA-300642.

24 SA-600835.

25 SA-600836.

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1 SA-600149.

2 Court Exhibit 69:

3 SA-000099.

4 SA-000434.

5 SA-000071.

6 SA-000181.



7 SA-000225.  
8 SA-000014.  
9 SA-000229.  
10 SA-000292.  
11 SA-000169.  
12 SA-000091.  
13 SA-000228.  
14 SA-000318.  
15 SA-000168.  
16 SA-000233.  
17 SA-000316.  
18 SA-000227.  
19 SA-000314.  
20 SA-000235.  
21 SA-000223.  
22 SA-000226.  
23 SA-000025.  
24 SA-000465.  
25 SA-000029.

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1 SA-000027.  
2 SA-000290.  
3 SA-000547.  
4 ARF-0001281.  
5 SA-000026.  
6 SA-0001923.  
7 SA-000231.  
8 SA-00214.  
9 SA-000187.  
10 SA-000033.  
11 SA-000002.  
12 SA-000073.  
13 SA-000435.  
14 SA-000095.  
15 SA-000121.  
16 SA-00093.  
17 SA-000118.  
18 SA-000094.  
19 SA-000102.  
20 SA-000116.  
21 SA-000023.  
22 SA-000180:  
23 SA-000126.  
24 SA-000184.  
25 SA-000114.

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1 SA-000092.  
2 SA-000124.  
3 SA-000111.  
4 SA-000112.  
5 SA-000096.  
6 SA-000090.  
7 SA-000108.  
8 SA-000123.  
9 SA-000433.  
10 SA-000087.  
11 SA-000107.  
12 SA-000088.  
13 SA-000105.  
14 SA-000098.  
15 SA-000100.

16 SA-000106.  
17 SA-000103.  
18 SA-000440.  
19 SA-000470:  
20 SA-000110.  
21 SA-000097.  
22 SA-000546.  
23 SA-000178.  
24 SA-000544.  
25 SA-000172.

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1 SA-000174.  
2 SA-000232.  
3 SA-000234.  
4 SA-000317.  
5 SA-000015.  
6 SA-000313.  
7 SA-000224.  
8 SA-000230.  
9 SA-000028.  
10 SA-000195.  
11 SA-000194.  
12 SA-000023.  
13 SA-000005.  
14 SA-000122.  
15 SA-000543.  
16 SA-000315.  
17 SA-000545.  
18 Court Exhibit 70:  
19 ARF-001951.  
20 ARF-001953.  
21 GD-000005.  
22 GD 300040.  
23 GK-300167.  
24 GK 300198.  
25 GK-300316.

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1 GK 300330.  
2 GM-300043.  
3 SA-300185.  
4 SA-300484.  
5 SA-300495.  
6 SA-300510.  
7 SA-300735.  
8 SA-300736.  
9 SA-300737.  
10 SA-300738.  
11 SA-300739.  
12 SA-300740.  
13 SA-300741.  
14 SA-300742.  
15 SA 300743.  
16 SA-300744.  
17 SA-300745.01.  
18 SA-300745.08.  
19 SA 300752.  
20 SA-400024.  
21 SA-400186.  
22 SA-400278.  
23 SA-400514.  
24 SA-400524.

25 TG-000002.

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1 TG-000237.  
2 6412.  
3 GR-001212.  
4 SA-100003.  
5 SA-100018.  
6 SA-100019.  
7 SA-100020.  
8 SA-200326.  
9 SA-200329.  
10 SA-300259.  
11 SA-300261.  
12 SA-3002636789.  
13 SA-3002716789.  
14 SA-3002736789.  
15 SA-300275.  
16 SA-300276.  
17 SA-300277.  
18 SA-300281.  
19 SA-300294.  
20 SA-3003427.  
21 SA-300331.  
22 SA-300360.  
23 SA-300364.  
24 SA-300377.  
25 SA-300459.

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1 SA-300469.  
2 SA-300471.  
3 SA-300476.  
4 SA-300477.  
5 SA-300593.  
6 SA 300596.  
7 SA-300599.  
8 SA-300600.  
9 SA-300600.  
10 SA-300604.  
11 SA-300687.  
12 SA-305689.  
13 SA-300696.  
14 SA-300698.  
15 SA-300699.  
16 SA-300721.  
17 SA-300722.  
18 SA-300323.  
19 SA-300730.  
20 SA-300732.  
21 SA-300733.  
22 SA-300734.  
23 SA-300746.  
24 SA-300747.  
25 SA-300748.

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1 SA-300749.  
2 SA-300750.  
3 SA-300751.  
4 SA-300753.  
5 SA-300754.  
6 SA-300757.

7 SA-400313.  
8 SA-400314.  
9 SA-400351.  
10 SA-400354.  
11 SA-400356.  
12 SA-400359.  
13 SA-400361.  
14 SA-400363.  
15 SA-400364.  
16 SA-400371.  
17 SA-400372.  
18 SA-400390.  
19 SA-400396.  
20 SA-400415.  
21 SA-400437.  
22 SA-400534.  
23 SA-400535.  
24 SA-400536.  
25 Plaintiff's Exhibit 35412.

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1 Plaintiff's Exhibit 42402.  
2 Plaintiff's Exhibit 42413.  
3 Plaintiff's Exhibit 43031.  
4 Plaintiff's Exhibit 43122.  
5 Plaintiff's Exhibit 43136.  
6 Plaintiff's Exhibit 43609.  
7 Plaintiff's Exhibit 43904.  
8 Plaintiff's Exhibit 43989.  
9 Plaintiff's Exhibit 80029.  
10 Plaintiff's Exhibit 80042.  
11 Plaintiff's Exhibit 80117.  
12 Plaintiff's Exhibit 80118.  
13 Plaintiff's Exhibit 80118.  
14 Plaintiff's Exhibit 80153.  
15 Plaintiff's Exhibit 80229.  
16 Plaintiff's Exhibit 80269.  
17 Plaintiff's Exhibit 80316.  
18 Plaintiff's Exhibit 80728.  
19 Plaintiff's Exhibit 81038.  
20 Defendant's Exhibit TG 000353.  
21 Defendant's Exhibit SA 300198.  
22 Defendant's Exhibit SA 400192.  
23 Defendant's Exhibit SA-400437.  
24 Defendant's Exhibit SA-400437.  
25 Defendant's Exhibit SA-300042.

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1 MR. KRAUS: Your Honor, I have just one document to  
2 offer in evidence as to which the plaintiffs have told me  
3 there is no objection, and that is Defendant's Exhibit as  
4 000546. This was used during Mr. Townsends' examination.  
5 THE COURT: Admitted.  
6 (So marked.)  
7 MR. BERNICK: Your Honor, in order to give you some  
8 relief from the mundane process of documents, I have some  
9 other issues that I'd like to raise with the court.  
10 THE COURT: Are there any other document issues?  
11 MR. BERNICK: I have some as well, but --  
12 MR. WESTBROOK: We have one a little behind.  
13 THE COURT: Let's take care of all the documents.  
14 MR. WESTBROOK: We have a list of Martin  
15 cross-examination documents, that was Court Exhibit 72, that

16 you marked the other day that I will hand back to the court.

17 THE COURT: Court's Exhibit what?

18 MR. WESTBROOK: 72. I will hand to the court.

19 THE COURT: Is that agreed to now?

20 MR. WESTBROOK: No, your Honor. Let me tell you  
21 where we are. There is one exhibit for the record, 50093,  
22 which was some polling data. Defendants ask that we add some  
23 pages, they have given us the pages and we have agreed to add  
24 those pages.

25 THE COURT: Admitted with that change.

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1 MR. WESTBROOK: There are four ads which are 76050,  
2 .0135, 135 .911, .913 --

3 THE COURT: Wait a minute.

4 MR. WESTBROOK: .92 --

5 THE COURT: Excuse me.

6 MR. WESTBROOK: 0135 --

7 THE COURT: May I see 76050, please. 135. I don't  
8 see the others.

9 MR. WESTBROOK: You will see .911. Under that  
10 is .913. Two under that is .924. The defendants want to  
11 preserve their objection. Those we are pre-53 ads that I used  
12 with Professor Martin who went back to 1600.

13 THE COURT: They are all going in.

14 MR. WESTBROOK: The only other item we have, your  
15 Honor, is I used with Professor Martin a 1977 Federal Trade  
16 Commission review of polls and I read to him certain pages  
17 from the overview.

18 We move to put this in as a 1977 government report.  
19 The defendant says it's a learned treatise and only want those  
20 pages in --

21 THE COURT: That's all I want. It's much too  
22 complicated. What number is this?

23 MR. WESTBROOK: 50379.01.

24 THE COURT: Yes. Only those pages are admitted, and  
25 the title page.

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1 MR. WESTBROOK: I read from page I and II.

2 THE COURT: All right. With those rulings, Court  
3 Exhibit 72 is admitted. I'm handing it to the reporter to  
4 please include it in the transcript at this point as  
5 admitted.

6 Court Exhibit 72:

7 255.

8 318.

9 742.

10 2019 (50093).

11 3084.

12 5026.

13 5143.

14 5414.

15 5435.

16 7016.

17 7692.

18 7738.

19 7749.

20 8023.

21 8717.

22 9445.

23 10021.

24 13762.

25 14664.

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1 18147.  
2 20022.  
3 28962.  
4 32088.  
5 37087.  
6 43305.02.  
7 44354.  
8 44365.  
9 44530.  
10 44531.  
11 44532.  
12 50093.  
13 50379.01.  
14 50507.  
15 50724 (50731).  
16 76050.0135.  
17 76050.0145.  
18 76050.0468.  
19 76050.911.  
20 76050.913.  
21 76050.921.  
22 76050.922.  
23 76050.924.  
24 76196.003.  
25 76341.002.

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1 76341.015.  
2 76341.015 (a).  
3 80451.  
4 80596.  
5 80691.  
6 80724.  
7 Martin Movie Clips 1, 2, 3, 4, 5 and 6.  
8 Martin TV Clips 3, 6, 7 and 9.  
9 Martin videos 1, 2, 4, 5 and 8.  
10 Martin Demonstrative 3.  
11 P Martin 1.  
12 P Martin 1 B (50734 B).  
13 P Martin 2 (80627)  
14 MR. WESTBROOK: Your Honor, I think Mr. Bernick  
15 wants to reserve the right to move to strike on the list  
16 should he find something that he wants to argue about.  
17 THE COURT: I will take that at any time, a motion  
18 to strike.  
19 MR. KRAUS: One last thing with respect to the  
20 list. Several of those documents were the R.J. Reynolds  
21 letters to schools and, obviously, I had objected to those  
22 previously, your Honor, and I want the record to reflect that  
23 we continue to object to those.  
24 THE COURT: Overruled.  
25 MR. MARK: Your Honor, plaintiffs mentioned 911,

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1 which is a Chesterfield add from Liggett. I think plaintiff  
2 is in agreement that the language noted on black on the left  
3 margin of that exhibit has nothing to do with that ad and  
4 should be redacted.  
5 MR. WESTBROOK: We agree. I don't think it's on  
6 other copy. We agree to that.

7 THE COURT: Redact it. Admitted. Any other  
8 document points?  
9 MR. BERNICK: I have a document issue. Court's  
10 Exhibit 75 is materials used with Wecker and I don't believe  
11 there's any objection to those.  
12 THE COURT: Court's Exhibit 75 is admitted.  
13 MR. STENGEL: No objection.  
14 THE COURT: I'm handing it to the reporter. Would  
15 you please enter it into the record at this point.  
16 Court Exhibit 75:  
17 GZ-201203 (aka GN-100316).  
18 GZ-201204 (aka GN-100315).  
19 GZ-201264.  
20 WZ-000590.  
21 Wecker 001 (aka DEM-012072).  
22 Wecker 002 (aka DEM-012073).  
23 Wecker 003 (aka DEM-012104).  
24 Wecker 004 (aka DEM-0121103).  
25 Wecker 005 (aka DEM-012074).

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1 Wecker 006 (aka DEM-012076).  
2 Wecker 007 (aka DEM-012077).  
3 Wecker 008 (aka DEM-012078).  
4 Wecker 009 (aka DEM-012079).  
5 Wecker 010 (aka DEM-012079 A).  
6 Wecker 011 (aka DEM-012080).  
7 Wecker 012 (aka DEM-012081).  
8 Wecker 013 (aka DEM-012082).  
9 Wecker 014 (aka DEM-012085).  
10 Wecker 015 (aka DEM-012086).  
11 Wecker 016 (aka DEM-012088).  
12 Wecker 017 (aka DEM-012089).  
13 Wecker 018 (aka DEM-012090).  
14 Wecker 018 A (aka DEM-0121105).  
15 Wecker 019 (aka DEM 012091).  
16 Wecker 020 (aka DEM 012075).  
17 Wecker 022 (aka DEM-0120092).  
18 Wecker 023 (aka DEM-0120095).  
19 Wecker 024 (aka DEM-012094).  
20 Wecker 024 A (aka DEM-012093).  
21 Wecker 026 (aka DEM-012097).  
22 Wecker 027 (aka DEM-012098).  
23 Wecker 025 (aka DEM-012096).  
24 Wecker 025 A (aka DEM-121106).  
25 Wecker 028 (aka DEM-0120099).

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1 Wecker 029.  
2 MR. BERNICK: Here's another list of materials that  
3 have been or will be used and we have not had the  
4 opportunity -- I know plaintiffs' counsel still hasn't  
5 received it. We would like to have it entered as a Court  
6 Exhibit.  
7 THE COURT: Court's Exhibit 81. I am returning it  
8 to the defendant for checking with the plaintiff.  
9 MR. BERNICK: Thank you.  
10 THE COURT: Anything further?  
11 MR. BERNICK: Yes. We have -- I will give this to  
12 you in a moment, we have a proposed instruction regarding --  
13 THE COURT: That ends our document problem?  
14 MR. BERNICK: I don't have any other document  
15 issues. I should say, we will reserve -- this is more a

16 substantive point -- DEM 12150, a demonstrative that we would  
17 used to place into context with Dr. Dunbar, the claim of the  
18 plaintiffs in this case, and we reserve on our right to  
19 supplement the record through Dr. Dunbar to have him respond  
20 to the plaintiffs' claim in the case, which we sill do not  
21 have. I want to make that clear on the record.

22 THE COURT: You can put it in next week if there's a  
23 basis.

24 MR. BERNICK: We would tender up to the court a  
25 proposed instruction regarding the Surgeon General 2000

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1 report.

2 THE COURT: Marked Court's Exhibit 82.

3 MR. WESTBROOK: We have just been handed this, your  
4 Honor.

5 THE COURT: Okay. Go over it over the weekend and  
6 I'll hear you on it on Monday. Yes, on Monday.

7 MR. BERNICK: Your Honor, there are a few other  
8 matters. Number one, we still do not have at this late date  
9 the damage claim for the plaintiffs.

10 It's now becoming so extreme as to be bizarre. Mr.  
11 Austern was so calm and fluid this morning, explaining the  
12 matrix, I don't know what the problem is, why we don't have  
13 numbers, but we don't have the numbers.

14 Can we find out when we're going to get them?

15 THE COURT: Yes. Do you have any indication from  
16 the Trust?

17 MR. STENGEL: I have been in this room all day, so  
18 it's hard for me to say.

19 THE COURT: When you get a chance, get on the phone  
20 and -- we have to have those numbers.

21 MR. STENGEL: I will give Mr. Bernick a call this  
22 evening and make sure he knows.

23 THE COURT: If you can't give them to us, I'm not  
24 going to let you go forward with the 2001 and 2002.

25 MR. STENGEL: Understood, your Honor.

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1 MR. BERNICK: Second, we would, on the basis of the  
2 testimony that was offered this morning from Dr. Harris and  
3 the further comments -- any information to the court --  
4 further comments by Dr. Wecker, we want to make sure that we  
5 preserve our record and renew our motion to strike any  
6 testimony from Dr. Harris on any matter, and in particular  
7 those matters that were provided to us within the last  
8 twenty-four hours.

9 (Continued next page)

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1 THE COURT: Decision reserved until I hear his  
2 testimony.

3 MR. BERNICK: Second to last, we have some -- we are  
4 trying to expedite the completion of the case and I have made  
5 some proposals to counsel regarding the submission of  
6 deposition testimony just into the record without taking up  
7 the jury's time to hear it and other matters. We are trying  
8 to move forward.

9 I think that you now have heard from our last live  
10 witness so it is just a matter at this point of some  
11 videotapes. We are even prepared to cut those down if we can  
12 develop some notion of what the plaintiffs' really anticipate  
13 the schedule is going to be with their matters.

14 THE COURT: You mean, the -- I assume that you were  
15 going to have Doctor Wecker, if he is available, listen in on  
16 the testimony.

17 MR. BERNICK: Yes.

18 THE COURT: You might use him. I will take him by  
19 telephone.

20 MR. BERNICK: Well, actually, what we would do if  
21 they are going to call Doctor Harris on Tuesday, we will want  
22 to put Doctor Wecker on the stand to respond to that.

23 THE COURT: Physically or by telephone?

24 MR. BERNICK: Absolutely, physically.

25 THE COURT: Okay. You may not get to summations

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1 until Wednesday.

2 MR. BERNICK: We are prepared to try to cut back on  
3 the depositions.

4 THE COURT: I am not in any rush. We have moved very  
5 quickly.

6 MR. BERNICK: If we in fact complete the proofs on  
7 Tuesday, what would be Your Honor's anticipation about  
8 closings?

9 THE COURT: We have that one juror who is off one day  
10 next week.

11 MR. BERNICK: Thursday.

12 Do we know what time of day he has the appointment?

13 THE COURT: I made inquiry of Ms. Lowe. Apparently,  
14 he is buying merchandise or something for the year and he has  
15 to go through a trade show from one floor after another. He  
16 indicated he probably needed a full day, but we will see if we  
17 can reduce that. I don't think we can have much hope of  
18 that.

19 MR. BERNICK: If that's so, if we were finishing the  
20 proofs on Tuesday, and we had a dark day on Thursday, when  
21 would be your inclination to have closings take place?

22 THE COURT: Well, Wednesday and Friday, I suppose.  
23 The alternative would be just close down for the rest of that  
24 week and start fresh on the following Monday.

25 MR. BERNICK: My --

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1 THE COURT: It would give us all breathing room on  
2 the charge and summations, on getting the evidence shaped up  
3 and everything else. In view --

4 MR. BERNICK: My sense is that juror number one, and  
5 maybe there are others, are somewhat anxious to get back to  
6 their ordinary lives.

7 THE COURT: That's the problem. But they really  
8 can't complain. They were promised a ten-week trial. That  
9 may happen of course, or more.  
10 I will think about it. I always prefer to move  
11 ahead.  
12 MR. BERNICK: Okay. The last -- the last point, and  
13 I am reluctant to raise it because it will sound out of place,  
14 but when Your Honor put the question to the last witness about  
15 the relevance of her testimony, when she said I think, in  
16 essence, that she didn't believe that there was sufficient  
17 information to reach a clinical diagnosis with respect to a  
18 claim.  
19 THE COURT: Yes.  
20 MR. BERNICK: It made it sound as if what the Court  
21 is saying is that it doesn't make a difference, it is not  
22 precisely relevant, whether there was a proper diagnosis or  
23 not, as long as it was reasonable for the Trust to pay.  
24 THE COURT: Yes. All right.  
25 You are right on that. I agree.

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1 Give me a request to charge and I will give it.  
2 MR. BERNICK: I guess Monday at ten we are to be here  
3 to take up the charge?  
4 THE COURT: Well, I was thinking of nine.  
5 MR. BERNICK: I'm sorry?  
6 THE COURT: I was thinking of 9:00 o'clock.  
7 MR. BERNICK: I don't think we have anything else to  
8 do, Your Honor, other than to work on our closings. So we are  
9 more than happy to be here at 9:00 o'clock.  
10 THE COURT: It may take more time. There may be  
11 document problems that come up because you are putting  
12 together your final lists and so on.  
13 Is it reasonable? I don't want to press you.  
14 MR. BERNICK: It's fine.  
15 THE COURT: 9:00 o'clock. Then we can break early.  
16 MR. SCHROEDER: In that regard, in order to be able  
17 Monday to do what we need to do with documents, we have been  
18 trying to get from the plaintiffs their videos that they have  
19 shown because they haven't been transcribed during the trial.  
20 We really need to have those this weekend to be prepared  
21 Monday to deal with those. Can we get those sometime this  
22 weekend?

23 MR. WESTBROOK: I just saw I think the last few video  
24 transcribed transcripts to be checked and then we are going to  
25 submit them to the other side to be sure the transcripts,

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1 everybody matches what was played. I think that's in  
2 process. People in our office --  
3 MR. SCHROEDER: Can we get them before mid-day  
4 tomorrow? Is that a problem?  
5 MR. WESTBROOK: Yes.  
6 MR. SCHROEDER: Thank you.  
7 MR. WESTBROOK: We will convey that. I don't think  
8 it should be a problem, Your Honor. If it is we will call.  
9 We will relay the message when we go back.  
10 THE COURT: Anything further?  
11 I was a little troubled. There are a number of  
12 troublesome problems with this charge, obviously. If you have  
13 any full submission on the issue of joint and several -- I  
14 take it, the defendants want me to set it up at least so the  
15 jury can decide whether there is joint liability or individual

16 liability. I would suppose Liggett would want that.  
17 MR. FEIWUS: Yes, Your Honor.  
18 THE COURT: I will have to have a charge. I am not  
19 sure that we have gone into it in sufficient detail.  
20 MR. BERNICK: We will think about that.  
21 THE COURT: There was something else I was troubled  
22 by.  
23 We may move around parts. You'll also have to have  
24 your statements of factual theory for the front end.  
25 MR. MANSFIELD: Your Honor has in mind two paragraphs

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1 or so?  
2 THE COURT: Yes, something like that.  
3 MR. MANSFIELD: On Monday can we also take up the  
4 proposed verdict form as well?  
5 THE COURT: Yes. I know the defendants want a much  
6 more comprehensive one.  
7 All right. Thanks very much for all of your help.  
8 Enjoy your weekend.  
9 (Recess taken until 9:00 o'clock, Monday, January 15,  
10 2001.)  
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18	Court Exhibit 64:	
19	WZ-001401.	
20	WZ-001387.	
21	GB-300042.	
22	SA-300718.	
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24	SA-300620.	

25 SA-300637.  
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1 SA 300638.  
2 SA-300639.  
3 SA-300640.  
4 SA-300641.  
5 SA-300642.  
6 SA-600835.  
7 SA-600836.  
8 SA-600149.  
9 Court Exhibit 69:  
10 SA-000099.  
11 SA-000434.  
12 SA-000071.  
13 SA-000181.  
14 SA-000225.  
15 SA-000014.  
16 SA-000229.  
17 SA-000292.  
18 SA-000169.  
19 SA-000091.  
20 SA-000228.  
21 SA-000318.  
22 SA-000168.  
23 SA-000233.  
24 SA-000316.  
25 SA-000227.

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1 SA-000314.  
2 SA-000235.  
3 SA-000223.  
4 SA-000226.  
5 SA-000025.  
6 SA-000465.  
7 SA-000029.  
8 SA-000027.  
9 SA-000290.  
10 SA-000547.  
11 ARF-0001281.  
12 SA-000026.  
13 SA-0001923.  
14 SA-000231.  
15 SA-00214.  
16 SA-000187.  
17 SA-000033.  
18 SA-000002.  
19 SA-000073.  
20 SA-000435.  
21 SA-000095.  
22 SA-000121.  
23 SA-00093.  
24 SA-000118.  
25 SA-000094.

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1 SA-000102.  
2 SA-000116.  
3 SA-000023.  
4 SA-000180:  
5 SA-000126.  
6 SA-000184.

7 SA-000114.  
8 SA-000092.  
9 SA-000124.  
10 SA-000111.  
11 SA-000112.  
12 SA-000096.  
13 SA-000090.  
14 SA-000108.  
15 SA-000123.  
16 SA-000433.  
17 SA-000087.  
18 SA-000107.  
19 SA-000088.  
20 SA-000105.  
21 SA-000098.  
22 SA-000100.  
23 SA-000106.  
24 SA-000103.  
25 SA-000440.

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1 SA-000470:  
2 SA-000110.  
3 SA-000097.  
4 SA-000546.  
5 SA-000178.  
6 SA-000544.  
7 SA-000172.  
8 SA-000174.  
9 SA-000232.  
10 SA-000234.  
11 SA-000317.  
12 SA-000015.  
13 SA-000313.  
14 SA-000224.  
15 SA-000230.  
16 SA-000028.  
17 SA-000195.  
18 SA-000194.  
19 SA-000023.  
20 SA-000005.  
21 SA-000122.  
22 SA-000543.  
23 SA-000315.  
24 SA-000545.

25 Court Exhibit 70:

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1 ARF-001951.  
2 ARF-001953.  
3 GD-000005.  
4 GD 300040.  
5 GK-300167.  
6 GK 300198.  
7 GK-300316.  
8 GK 300330.  
9 GM-300043.  
10 SA-300185.  
11 SA-300484.  
12 SA-300495.  
13 SA-300510.  
14 SA-300735.  
15 SA-300736.

16 SA-300737.  
17 SA-300738.  
18 SA-300739.  
19 SA-300740.  
20 SA-300741.  
21 SA-300742.  
22 SA 300743.  
23 SA-300744.  
24 SA-300745.01.  
25 SA-300745.08.

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1 SA 300752.  
2 SA-400024.  
3 SA-400186.  
4 SA-400278.  
5 SA-400514.  
6 SA-400524.  
7 TG-000002.  
8 TG-000237.  
9 6412.  
10 GR-001212.  
11 SA-100003.  
12 SA-100018.  
13 SA-100019.  
14 SA-100020.  
15 SA-200326.  
16 SA-200329.  
17 SA-300259.  
18 SA-300261.  
19 SA-3002636789.  
20 SA-3002716789.  
21 SA-3002736789.  
22 SA-300275.  
23 SA-300276.  
24 SA-300277.  
25 SA-300281.

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1 SA-300294.  
2 SA-3003427.  
3 SA-300331.  
4 SA-300360.  
5 SA-300364.  
6 SA-300377.  
7 SA-300459.  
8 SA-300469.  
9 SA-300471.  
10 SA-300476.  
11 SA-300477.  
12 SA-300593.  
13 SA 300596.  
14 SA-300599.  
15 SA-300600.  
16 SA-300600.  
17 SA-300604.  
18 SA-300687.  
19 SA-305689.  
20 SA-300696.  
21 SA-300698.  
22 SA-300699.  
23 SA-300721.  
24 SA-300722.

25 SA-300323.

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1 SA-300730.  
2 SA-300732.  
3 SA-300733.  
4 SA-300734.  
5 SA-300746.  
6 SA-300747.  
7 SA-300748.  
8 SA-300749.  
9 SA-300750.  
10 SA-300751.  
11 SA-300753.  
12 SA-300754.  
13 SA-300757.  
14 SA-400313.  
15 SA-400314.  
16 SA-400351.  
17 SA-400354.  
18 SA-400356.  
19 SA-400359.  
20 SA-400361.  
21 SA-400363.  
22 SA-400364.  
23 SA-400371.  
24 SA-400372.  
25 SA-400390.

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1 SA-400396.  
2 SA-400415.  
3 SA-400437.  
4 SA-400534.  
5 SA-400535.  
6 SA-400536.  
7 Plaintiff's Exhibit 35412.  
8 Plaintiff's Exhibit 42402.  
9 Plaintiff's Exhibit 42413.  
10 Plaintiff's Exhibit 43031.  
11 Plaintiff's Exhibit 43122.  
12 Plaintiff's Exhibit 43136.  
13 Plaintiff's Exhibit 43609.  
14 Plaintiff's Exhibit 43904.  
15 Plaintiff's Exhibit 43989.  
16 Plaintiff's Exhibit 80029.  
17 Plaintiff's Exhibit 80042.  
18 Plaintiff's Exhibit 80117.  
19 Plaintiff's Exhibit 80118.  
20 Plaintiff's Exhibit 80118.  
21 Plaintiff's Exhibit 80153.  
22 Plaintiff's Exhibit 80229.  
23 Plaintiff's Exhibit 80269.  
24 Plaintiff's Exhibit 80316.  
25 Plaintiff's Exhibit 80728.

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1 Plaintiff's Exhibit 81038.  
2 Defendant's Exhibit TG 000353.  
3 Defendant's Exhibit SA 300198.  
4 Defendant's Exhibit SA 400192.  
5 Defendant's Exhibit SA-400437.  
6 Defendant's Exhibit SA-400437.

7 Defendant's Exhibit SA-300042.  
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9 Court's Exhibit 75 5942  
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12 DEM 012137 and 38 5844  
13 M 1 5855  
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21 911 5941  
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